

**Trying to make sense of the chaos: Clinical psychologists'
experiences and perceptions of clients with 'borderline
personality disorder'**

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DECLARATION

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis, or any part of it, has not been submitted for any other degree or professional qualification.

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ABSTRACT

Evidence of negative perceptions of clients with ‘borderline personality disorder’ (BPD) in mental health professionals has been well documented (e.g. Lewis & Appleby, 1988; Markham & Trower, 2003; Nehls, 2000). Despite recent recommendations by the British Psychological Society that clinical psychologists should become clinical leaders in the area of BPD, little is known however, about the perspectives of this particular profession on the BPD client group. Using a qualitative methodology, the primary aim of the present study was to explore clinical psychologists’ experiences and perceptions of clients with BPD.

Sixteen clinical psychologists (including both trainees and fully qualified staff) participated in focus groups. All four groups were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (Smith, 1996).

The following eight superordinate themes emerged from the analysis: ‘negative perceptions of the client’; ‘undesirable feelings in the psychologist’; ‘positive perceptions of the client’; ‘desirable feelings in the psychologist’; ‘trying to make sense of the chaos’; ‘working in contrast to the system’; ‘awareness of negativity’; and ‘improving our role’. Some differences in the emergence of themes between participants at different stages in their careers were noted. For example, ‘positive perceptions of the client’ and ‘desirable feelings in the psychologist’ were more evident in the narratives of fully qualified staff.

Implications include concerns regarding the therapeutic relationship and the possibility of the unintentional perpetuation of the negativity surrounding this client group. However, hope for change is also implied, as clinical psychologists appeared to engage in a range of processes in order to attempt to bring some understanding to the presenting problems of people with BPD, and conveyed a sense of a need to improve their role in this area, as well as ways of doing so. Moreover, the positive perceptions and desirable feelings expressed contrast with the pejorative connotations of the BPD label being seen as unchangeable, and challenge the notion

that such clients are only associated with negative feelings in staff. It is recommended that ideas generated within the focus groups, such as providing more experience and teaching on BPD for trainees, as well more support for fully qualified clinical psychologists working with these clients, are taken forward. Suggestions for future research include the exploration of the perspectives of clinical psychologists in different settings, such as learning disabilities services, and the quantitative investigation of the noted differences between clinical psychologists at different stages in their careers.

1. BACKGROUND

Mental health professionals are increasingly met with clients whose intense emotions and repeated, ‘maladaptive’ behaviour patterns are challenging to understand and treat (Sable, 1997). Several of such individuals present with a cluster of symptoms and behaviours, classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association (APA), 1994), as ‘borderline personality disorder’ (BPD) (Sable, 1997). Research suggests that BPD is prevalent in around 10 to 20 per cent of clients in psychiatric outpatient settings, and 15 to 20 per cent of clients in psychiatric inpatient settings (Gunderson, 2001).

In the introduction to the present study, current understandings of BPD will be discussed, including controversies surrounding the diagnosis. Following this, perspectives of the British Psychological Society (BPS), clients with BPD diagnoses, and mental health professionals will be highlighted. The chapter will then proceed to discussing the relevance of staff perceptions in care-giving. Emphasising the gap in the literature regarding clinical psychologists’ (CPs’) perspectives on clients with BPD, the introduction will conclude with the rationale for the present study, including justifications for the use of a qualitative methodology, and finally, the study aims.

The background information reported has been gathered from a literature search conducted to clarify current understandings of BPD. The terms ‘borderline personality’, ‘client views’ ‘staff perceptions’, ‘clinical psychologist perceptions’, and variants of these, were searched via psycINFO, EMBASE, MEDLINE, EBM Reviews, and CINAHL databases. Additional relevant papers were identified, by examining reference lists in the articles initially found.

1.1 What is ‘Borderline Personality Disorder’?

1.1.1 The ‘Personality’ Concept

While people have tried to group individuals in relation to their characteristic approach to life since the time of the ancient Greeks, the concept of personality as a *stable* characteristic only emerged around a century ago (Alwin *et al.*, 2006). At that time, the most important psychological theories were those of psychoanalytic or Freudian thought, hence early understandings of both ‘normal’ and ‘abnormal’ personality were conceptualised by this approach (Tyrer, 2000). According to Freudian theory, an individual’s personality is governed by unconscious, irrational, and instinctual forces (Allen, 2000). From the 1930s onwards, the psychological study of personality grew and changed direction, with an emphasis on population studies as opposed to case studies (Alwin *et al.*, 2006). An example of such work is that of Eysenck (1967). Essentially, Eysenck’s theory postulates that personality can be described in terms of theoretical constructs termed ‘traits’ (e.g. ‘calm’, ‘outgoing’, ‘rigid’), which are based on intercorrelations between several different observed habitual responses (Eysenck & Eysenck, 1969).

Since the APA first described ‘personality *disorders*’ (PDs) in 1980 (APA, 1980), interest in ‘abnormal’ personality has flourished (Davidson, 2000). However, Livesley (2001) argues that the present approach to PDs in mental health settings ignores research on personality in the general population, which now spans several decades (Alwin *et al.*, 2006).

1.1.2 Classification of ‘Personality Disorders’

At present, systems of PD classification are categorical. According to DSM-IV, personality traits are defined as enduring patterns of perceiving, relating to, and thinking about oneself and the environment, shown in a broad range of significant social contexts (APA, 1994). When such traits are inflexible and maladaptive, leading to impairment in an individual’s social or occupational functioning, or resulting in distress to that person, the term PD is used (APA, 1994). DSM-IV describes PD as enduring patterns of inner experience (i.e. cognitions and affects),

interpersonal behaviour, and impulse control, that are markedly culturally deviant, and emerge in early adulthood or adolescence (APA, 1994). Ten categories of PD are specified, each containing seven to nine criteria. The PD categories are divided into the following three clusters: odd/eccentric, dramatic/erratic, and anxious/fearful.

1.1.3 Classification of ‘Borderline Personality Disorder’

The DSM-IV category of BPD falls within the dramatic/erratic cluster. It is defined as a pattern of instability in interpersonal relationships, self-image, and affects, in addition to marked impulsivity (APA, 1994). To be diagnosed, a minimum of five criteria must be evident (see Appendix I).

1.1.4 Controversies Surrounding the ‘Personality Disorder’ Diagnosis

The categorical classification of PD may be seen as advantageous, as it is easy for clinicians to use when it is necessary to make quick diagnoses with large numbers of clients whom they meet with briefly, and can provide an awareness of a range of unobserved behaviours that are frequently correlated with those that have been observed (Millon, 1993). However, categorical classification is seen by many clinicians as limited in its usefulness (Alwin *et al.*, 2006), and the term PD is often associated with confusion and stigma (Jarrett, 2006). Several of such controversies are outlined below.

The Oxford English Dictionary defines the word ‘personality’ as ‘the characteristics or qualities that form an individual’s character’. Being one of the most abstract words in the English language (Derksen, 1995), people have implicit understandings of its concept (Markham & Trower, 2003). Throughout the last century, the use of the word ‘personality’ has traded meanings with terms such as ‘type’, ‘self’, and ‘character’ (Berrios, 1993), meaning that people’s concepts of personality may be diverse, and may differ from the clinical diagnostic meaning of PD (Markham & Trower, 2003). Indeed, from a psychological perspective, there is no universally agreed definition of personality (Alwin *et al.*, 2006).

More disagreement arises in PD theories themselves. As such, categories in the DSM-IV reflect a variety of personality theories, which many researchers believe has resulted in a number of practical difficulties (Alwin *et al.*, 2006). For instance, if different methods of assessment are conducted, there is generally low agreement on the diagnosis of specific categories of PD (Perry, 1992), indicating problems with the validity of the categories (Alwin *et al.*, 2006).

It is argued that the categorical nature of the diagnosis contributes to the misconception that ‘psychopathological syndromes’ are discrete entities, rather than simple concepts that help focus observations (Millon, 1993). Additionally, the quantity of types are much fewer than the individual differences noted in practice, leading to difficulties in allocating many clients to the few categories available (Millon, 1993). Similarly, clinicians often report that as they learn more about a client, the difficulty in fitting him/her into one single category increases (Millon, 1993), suggesting that the categories are not independent (Alwin *et al.*, 2006). Finally, as numerous classification systems have been devised over the last century, a lack of consensus among categorists brings the validity of any categorical system into question (Millon, 1993).

It has been argued, therefore, that if psychologists cannot agree on what precisely personality is or how to measure it, then undoubtedly it cannot be meaningful or acceptable to label an individual as having a PD (Jarret, 2006). Moreover, the pejorative connotations of such a label mean that it is unlikely to be helpful for an individual who meets criteria for the disorder (Davidson, 2000). Being told that their very character is disordered is likely to be very demeaning (Jarret, 2006). For many, the label of a PD may also be counterproductive, as it may imply that their difficulties are unchangeable, as personality is generally thought of as fundamental to one’s concept of self (Davidson, 2000).

1.1.5 Controversies Surrounding the ‘Borderline Personality Disorder’ Diagnosis

In addition to the above, further controversies surround the specific diagnosis of BPD. Sable (1997) highlights how the meanings of the term BPD have changed, thus suggesting its ambiguity. Claims have been made that several of Freud’s renowned ‘neurotic patients’ would meet the BPD criteria (Finn & Sperling, 1993), and that perhaps early diagnoses such as ‘hysterical’ are now more accurately recognized as BPD (Minde & Frayn, 1992). While DSM-IV lists a borderline profile, there is still debate over whether individuals who experience this cluster of symptoms comprise one distinct diagnostic category (Fromm, 1995). For example, Fromm (1995) contends that rather than an entity, BPD lies on a developmental border between neurosis and psychosis. Nehls (1998) asserts that the BPD diagnosis is poorly defined and misunderstood.

Again, the apparent comorbidity of BPD with other PDs, as well as DSM-IV Axis I disorders brings the validity BPD diagnosis into further question. For example, research with an inpatient population has suggested that there is frequently overlap in the symptoms of BPD with symptoms of mood disorders, anxiety disorders, and eating disorders (Zanarini *et al*, 1998). The authors claim that such comorbidity is actually a marker for BPD, and that the finding that 75 per cent of those with BPD exhibited a pattern of comorbidity and 75 per cent of those with other PD diagnoses did not, establishes the validity of BPD. However, it is argued that such conclusions are misleading. Becker (2000) asserts that the comorbidity is, on the contrary, evidence for the boundaries of the BPD diagnosis being poorly differentiated.

A further controversy centres around the breadth of the BPD diagnostic criteria. Research has demonstrated 93 ways in which criteria could be combined and still lead to a DSM-III-R BPD diagnosis (Stone, 1990). Given the addition of a new criterion to the DSM-IV, there are now likely to be even more possible combinations (Becker, 2000). BPD has been referred to as a ‘wastebasket diagnosis’ (Nehls, 1998), and Becker (2000) contends that the diagnosis is ‘now little more than

shorthand for a difficult, angry female client certain to give the therapist countertransferential headaches' (p.423).

Research suggests that around 80 per cent of clients with BPD are women (e.g. Widiger & Weissman, 1991). Interestingly, when presented with identical case descriptions, clinicians were more inclined to diagnose BPD in women and antisocial PD in men (Adler *et al.*, 1990). This suggests rather stereotyping rather than actual effects of gender on prevalence of BPD (Alwin *et al.*, 2006). It has been hypothesised that, historically, more women have been given the BPD diagnosis due to gender stereotypes and early theorising about the development of BPD (Nehls, 1998). For example, one of the first theories centred around inadequate mothering as the cause of BPD, with mothers of people with BPD also being assumed to be 'borderline' (Masterson, 1976). Nehls (1998) argues that such theories served to put women at greater risk of receiving the diagnosis, and that this gender bias is perpetuated by mental health professionals ignoring current theories of BPD.

Finally, in addition to the pejorative connotations of the diagnosis of PD in general, the BPD diagnosis carries unique burdens. For example, in a study of court law, it was suggested that such individuals are often considered 'mentally disabled', and consequently, subject to compulsory hospitalisation or medication, and loss of child custody (Stefan, 1998), yet they are also often regarded as not 'mentally disabled' to the degree that would allow them to obtain disability benefits, or to claim damages in abuse cases (Becker, 2000). Perhaps this paradox results from being seen as being on the 'borderline'.

1.1.6. Dimensional Approaches

Given the criticisms of the categorical approach to PD, many researchers argue that variations between 'normal' and 'disordered' personality are more accurately represented on a continuum (e.g. Widiger, 1992). Such dimensional approaches are rooted in the decades of personality research conducted in academic psychology. According to Costa & McCrae's (1992) five-factor model of personality, the factors of neuroticism, extraversion, openness to experience, agreeableness, and

conscientiousness, are sufficient to account for the total variance in the individual personality traits. Interestingly, studies indicate that the structure of traits in PDs, including that of BPD, also reflect the 'Big Five' (e.g. Clark *et al.*, 1996), thus providing support for the notion of the personality continuum. Indeed, Alwin *et al.* (2006) suggest that it is unnecessary to have a separate trait language for describing PDs. In this sense, PDs can be represented as patterns of extremes on different dimensions (Widiger & Frances, 1994).

However, it appears that applying a dimensional approach to PD is complex. Regarding BPD specifically, for example, while research has indicated that the characteristic dimensional profile is one of high neuroticism and low agreeableness (e.g. Pukrop, 2002) and it has been consistently demonstrated that such dimensional profiles of individuals with BPD can be distinguished from those of the general population, differentiating it from the profiles of other PDs has proved more difficult (Morey *et al.*, 2002). Therefore, it had been suggested that different PDs may reflect different interactions among dimensions, as opposed to differences on single dimensions (Morey *et al.*, 2002).

The usefulness of a dimensional approach to PDs has been emphasised, in that it offers a more comprehensive description, and represents personality difficulties in terms of extremity rather than categories (Davidson, 2000). Nevertheless, it is limited in its ability to predict and explain individual behaviour (Alwin *et al.*, 2006). Thus, it appears that while the dimensional approach offers several advantages, it is also subject to controversy.

1.1.7. Millon's Prototypal Domain Approach

It is perhaps most notably in the model of personality posed by Millon (Millon, 2000), that dimensional and categorical approaches to describing PDs are combined to provide a more clinically useful way of classifying PDs, based on the continuous distribution of traits (Strack & Millon, 2007). In this 'prototypal domain approach', Millon (2000) argues that the heterogeneity of the DSM-IV PDs should be openly recognised, and that the distinction between such categories and the DSM-IV Axis I

clinical syndromes, may not be as important as was previously thought. To this end, he proposes a three-point continuum consisting of simple reactions (simple, singular symptom responses to neurochemical dysfunctions or stimulus experiences, which are independent from personality traits), complex syndromes (fairly distinct groupings of symptoms which are, to some degree, enmeshed and mediated by personality patterns), and personality patterns (an interconnected group of interpersonal styles, cognitive stances, intrapsychic processes, and biological temperaments) (Millon, 2000). Such personality patterns can be differentiated further still, into 'styles' (patterns of adaptive functioning) and 'pathologies' (patterns of maladaptive functioning) (Millon, 2000).

In order to elucidate the overlap between diagnostic groups, and to highlight the relationships between personality patterns and complex syndromes, Millon (2000) has generated a range of PD subtypes. These variations of the discrete entities of the PD categories in the DSM-IV are a reflection of empirical findings and clinical observations, and are intended to more closely correspond to the distinctive presentations of clients seen in real-life clinical settings, rather than those of 'textbook' PDs (Millon, 2000). The variants for BPD, for example, include an impulsive subtype with antisocial or histrionic traits, presenting as irritable, agitated and with 'incipient' suicide attempts, as well as a self-destructive subtype with depressive features, inward directed 'moody' behaviours, and parasuicidal acts (Millon, 2003).

The clinical utility of Millon's model of personality (Millon, 2000) lies in, for example, its ability to allow clinicians to quickly identify expected covariations within clinical groups (Millon, 2000). Furthermore, Millon's integrative approach to psychological assessment (Millon, 2003) by way of, namely, the Millon Clinical Multiaxial Inventory (MCMI), is specifically designed to diagnose and integrate Axis I and II disorders. Thus, for instance, this holistic clinical instrument can not only be utilised for the diagnosis of dysthymia, but has the further benefit of being capable of indicating that a client who is dysthymic also displays underlying characteristics of BPD (Millon, 2003). Notably, the normative data and standard scores for the MCMI

are based on clinical populations, which Millon (2003) argues, lends it more suitability for clinical assessment or screening than more general personality inventories, designed for ‘normal’ populations. Moreover, such an integrative approach to assessment can ultimately help to provide clinicians with a foundation for targeted therapies, whereby the focus of therapy begins with the particular characteristics of the client, and moves to the integrated use of different intervention methods and approaches to match the complexity of the individual client’s difficulties (see Millon, 2003).

However, as Millon (2003) himself highlights, there are several limitations to the use of self-report measures such as the MCMI. For example, clients with similar problems may interpret questions in a different way, and clients’ current mood states may affect their responses on measures of traits (Millon, 2003). Furthermore, Rogers *et al.* (1999) reviewed the evidence for the validity of the MCMI, and concluded that there are marked problems with the construct validity of this instrument. Yet, Rogers *et al.* (1999) also emphasise the good evidence for the construct validity of the MCMI in relation to a limited group of PDs, one of which is BPD. Therefore, it appears that the MCMI can provide useful descriptive data regarding this client group (Rogers *et al.*, 1999).

1.2 The British Psychological Society Viewpoint

With a view to clarifying the confusion, encouraging more research, and improving the provision of services for people with diagnoses of PD (Jarrett, 2006) the British Psychological Society (BPS) have recently published *Understanding Personality Disorder: A Report by the British Psychological Society* (Alwin *et al.*, 2006). The report acknowledges the scepticism that some psychologists might hold regarding the clinical utility of the concepts of ‘personality’ and PD. However, it highlights that many individuals referred to mental health services have considerable personality difficulties (Dolan-Sewell *et al.*, 2001), and that the effectiveness of interventions for major mental health problems may be reduced by such difficulties (Reich & Vasile,

1993). Thus, Alwin *et al.* (2006) stress the need for the impact of personality on mental health difficulties to be recognised, in order to provide better mental health services.

In line with Millon's model of personality (Millon, 2000), the BPS stance is that while a dimensional approach to PD assumes only varying degrees of dysfunction, as opposed to the discrete entities of the current classification system, these approaches are potentially compatible (Widiger & Frances, 1994). Categorical diagnoses could also be regarded to be on a continuous dimension where a somewhat arbitrary cut-off for diagnosis has been applied (Alwin *et al.*, 2006).

1.2.1 Origins and Interventions

As outlined by Alwin *et al.* (2006), there is no single known cause of PD. Instead, a combination of biological factors (e.g. temperament), psychological factors (e.g. post-traumatic stress disorder), and social factors (e.g. peer groups) appear to be implicated in its development. However, many people are resilient to biopsychosocial stress, due to protective factors such as resilient temperaments, alternative positive attachments, and adaptive social environments. Thus, PD may best be conceptualised within a stress vulnerability model: if an individual's vulnerability is high, a little environmental stress may be all that is needed to cause difficulties, whereas if an individual is more biologically or psychologically resilient, a higher level of environmental stress would be necessary for difficulties to develop (Alwin *et al.*, 2006).

Historically there has been a prevailing belief that people with PD are 'untreatable', implying that treatability is dependent on those diagnosed with PD, instead of a reflection of the present state of our knowledge (Alwin *et al.*, 2006). These individuals are 'heavy users' of mental health services. The highly variable pattern of services used ranges from accident and emergency services due to deliberate self-harm, to general practitioner appointments for pharmacotherapy (Alwin *et al.*, 2006).

Among the main psychological interventions used for addressing PDs, are dialectical behaviour therapy (DBT) and schema-focused therapy. In DBT (Linehan, 1993), a comprehensive treatment specifically designed for BPD, cognitive, behavioural, and psychodynamic approaches are combined, along with Eastern philosophical techniques, such as acceptance and mindfulness meditation. In this approach, BPD is viewed as a disorder of emotional regulation, and as such, self-harming behaviour is conceptualised as a coping strategy used by the client to reduce intense painful emotions (Alwin *et al.*, 2006). Thus, such behaviours are the target of intervention, which takes the form of both group and individual intervention components (Alwin *et al.*, 2006).

On the other hand, schema-focused therapy, developed by Young (1994), focuses on early maladaptive schemas. These are unconditional beliefs regarding oneself in relation to the environment (Young, 1994). Four schema modes, that is, groups of schemas manifest in pervasive patterns of thoughts, feelings and behaviours, are understood to be related to BPD (Giesen-Bloo *et al.*, 2006). These are the angry/impulsive child, the abandoned/abused child, the punitive parent, and the detached protector (Giesen-Bloo *et al.*, 2006). In schema-focused therapy, there is an assumption that a healthy adult mode is also partially present, and the aim is for the more dysfunctional schemas to no longer dominate the client's life. Such change is reached through an array of cognitive, behavioural, and experiential techniques, which focus on daily life and early traumatic experiences, as well as the therapeutic relationship (Giesen-Bloo *et al.*, 2006; Young, 1994).

Other examples of psychological interventions used include psychodynamic psychotherapy, cognitive behaviour therapy (CBT) and therapeutic communities. Indeed, there is no standard intervention for people with BPD, and as such, treatment is often unplanned, non-continuous, and fragmented (Nehls, 1998).

Unfortunately, evaluations of interventions have been fraught with methodological difficulties, such as high drop-out rates. However, recent literature reviews, for example, that of Bateman & Fonagy (2000), indicate that there are some promising

psychological interventions for PDs. For example, in one of the few systematic evaluations of outpatient interventions for BPD conducted to date, Linehan *et al.* (1991) demonstrate the effectiveness of DBT for reducing self-harm behaviour. In this randomised controlled trial (RCT), 22 female clients with BPD were randomised to DBT and 22 were randomised to a 'treatment as usual' control group. Those in the DBT group were less likely to make suicide attempts or to drop out of therapy, and spent less time as inpatients over the year of intervention. As highlighted by Bateman & Fonagy (2000) however, no differences on measures of hopelessness, depression or reasons for living were found between the two groups, and a one-year follow-up study revealed no differences between those who received DBT and those who were in the control group (Linehan *et al.*, 1993). Thus, while it appears that DBT can be an effective intervention for women with BPD, more follow-up studies are necessary to assess the long-term outcomes of this intervention (Alwin *et al.*, 2006).

More recently, Giesen-Bloo *et al.* (2006) have demonstrated the effectiveness of both schema-focused therapy and psychodynamically based transference-focused therapy, in reducing BPD specific and 'general psychopathological' dysfunction, changing associated personality characteristics, and improving quality of life, in a RCT with 88 participants with BPD. Schema-focused therapy was found to be more effective than transference-focused therapy on all measures. However, as the authors themselves highlight, the findings are limited due to factors such as a lack of a control group, and therefore further research is needed to corroborate the results (Giesen-Bloo *et al.*, 2006).

Additionally, Davidson *et al.* (2006) demonstrated the effectiveness of CBT for BPD in a RCT of CBT versus 'treatment as usual' with 106 participants. Both treatment arms showed reduced suicidal behaviour, reduced attendance at accident and emergency services, and reduced inpatient psychiatric stays over the two-year study period. However, there were improvements on the Brief Symptom Inventory (at the end of the intervention), and on the amount of suicidal acts, dysfunctional core beliefs and state anxiety (at two-year follow-up), in favour of CBT (Davidson *et al.*,

2006). These findings suggest that CBT, even when brief, may benefit clients with BPD, but that the extent of the outcomes should not be overstated (Davidson *et al.*, 2006).

At present it appears that no model or intervention is superior to others, but that developing a range of interventions encompassing several models would have the advantage of providing models that suit the needs of individual clients (Alwin *et al.*, 2006). The BPS also recommends that clinicians should use formulation (i.e. a contextual and explanatory framework that can help to raise a client's awareness of their own thoughts, feelings, and behaviours) to move beyond diagnosis, and to directly inform interventions which can lead to positive change (Alwin *et al.*, 2006).

1.2.2 The Role of Clinical Psychology

The BPS welcome the government's policy of ensuring that people with PDs are treated within core services in mental health settings, with access to multidisciplinary teams (Alwin *et al.*, 2006). The recently published guidelines from the National Institute for Mental Health in England (NIMHE) (NIMHE, 2003) also recommend that specialist personality disorder teams, which could be a bridge between clients with PDs and services, are set up. These teams may be able to uphold a more long-term approach to intervention, emphasising the need to develop care packages for preparing clients for intervention, the provision of an intervention package and support after intervention (Alwin *et al.*, 2006). The BPS recommends that such changes to working practices are likely to result in an increased demand for psychologists, as the profession's particular skills in assessment and formulation would be vital to such specialist multidisciplinary PD teams. Alwin *et al.* (2006) also highlight CPs' unique skills in merging information from both the academic and clinical knowledge base to develop individual intervention packages. They state that if the NIMHE (2003) guidelines which emphasise the primacy of psychological interventions are to be met, a change in service delivery from the medical model of treating observed symptoms in PD (e.g. anxiety) to a psychological approach, which places more emphasis on formulation, would need to be developed. The BPS goes

on to recommend that for such a change to be achieved, CPs would need to be employed as clinical leaders within the specialised PD teams. In these roles, CPs would be involved in assessment, intervention, research, training, supervision and consultancy.

However, it is important to view the above recommendations by the BPS with some caution. The implementation of the proposal that CPs should be employed as clinical leaders in the area of BPD will depend on whether or not the proposal is acknowledged, and furthermore, how it is viewed, by other professionals working in this area, who are not represented by the BPS. Such professional groups may have different views on clinical leadership in the area. Indeed, Nehls (2000) recommends that it is the psychiatric nursing profession who should assume leadership in the improvement of the quality of mental health services for people with BPD.

1.3 Client Perspectives

Despite the flourishing of research interest in PD, most of the literature focuses on intervention studies, with research on client perspectives being rare. However, when clients' perspectives have been investigated, the findings have been illuminating. For example, interpretative phenomenological research (see section 2.5.1) has revealed that while clients interviewed did not object to their diagnoses of BPD, they deplored the stereotypes and stigma associated with this label, and believed that service providers held preconceived and negative opinions of them (Nehls, 1999).

Continuing with this research approach, Nehls (2001) explored community mental health case management services in the US from the perspective of clients with BPD. Positive perceptions of case managers (CMs) were reported, with clients regarding them as reliable, resourceful, and respectful. Further qualitative research has similarly revealed that despite negative experiences and encountering negative staff attitudes, people with BPD valued their contact with psychiatric services, and viewed relationships as crucial in containing their distressing emotions (Fallon, 2003).

1.4 Staff Perspectives

Research on staff perspectives of clients with PD has also been revealing. Again using an interpretative phenomenological approach, Nehls (2000) found that CMs of clients with BPD reported that they struggled with expressing concerns in relation to self-harm and setting boundaries. Furthermore, interviews were laden with the use of stereotypical words to describe clients with BPD, such as ‘manipulative’ (Nehls, 2000). In light of the above client perspectives on what they value in their CMs, this finding appears somewhat ironic.

In a questionnaire study with 50 registered mental health nurses (RMNs), Markham & Trower (2003) compared causal attributions for challenging behaviours in clients who were diagnosed with BPD, depression, and schizophrenia. In line with the above findings, nursing staff reported less sympathy and less optimism towards clients with a diagnostic label of BPD, and regarded them as more in control of their negative behaviour than clients with a label of depression or schizophrenia. They also rated their experiences of working with clients with a BPD diagnosis as more negative than their experiences of working with clients with diagnoses of schizophrenia or depression. These findings of negative attitudes towards clients with BPD in nursing staff are supported by several previous studies (e.g. Fraser & Gallop, 1993; Gallop *et al.*, 1989).

As highlighted by the authors however, a qualitative approach may add to the validity of these findings. The research was concerned solely with stereotypical beliefs held by nursing staff towards female clients, whereas further contextual information may be used by staff making causal attributions in ‘real-life’ experiences (Markham & Trower, 2003).

Further evidence of negative attitudes towards clients described with a BPD label, in both RMNs and Health Care Assistants (HCAs), is reported by Markham (2003). In

this questionnaire study, staff expressed a desire for greater social distance from clients with a BPD label and rated them as more dangerous than those with a depression label. They also expressed less optimism for clients with a BPD label and rated their experiences of working with them as more negative than those with depression or schizophrenia. Interestingly, RMNs reported less negative attitudes towards clients with a label of schizophrenia than towards those with a label of BPD, while HCAs' attitudes regarding social distance and dangerousness were comparable for clients of both diagnostic labels. This suggests that such negative attitudes towards clients with a diagnosis of schizophrenia may reduce with knowledge, training, or other possible group differences, while those towards clients with a diagnosis of BPD may not (Markham, 2003).

Evidence of negative perceptions of clients with BPD has also been indicated in other professions. For example, Lewis & Appleby (1988) found that in response to a vignette, psychiatrists regarded clients with BPD diagnoses as more 'difficult' and less deserving of care than clients without this diagnosis, and viewed them as 'manipulative' and 'annoying'. In a questionnaire study with mental health professionals in an Area Mental Health Service, the majority of participants rated dealing with clients with BPD as moderately to very difficult, and more difficult than any other client group (Walter *et al.*, 2003). However, the majority also believed they had a role working with these clients, and reported being keen to gain further training in this (Walter *et al.*, 2003).

Brody & Farber (1996) found that in response to a vignette, CPs' ratings of anger and irritation were higher for clients with a BPD label than for clients with depression or schizophrenia labels, and their ratings of liking, empathy, and nurturance were lower for clients with BPD labels compared to clients with the other labels. Notably however, the findings also indicate that there are aspects of working with clients with BPD that may serve to counter these negative reactions (Brody & Farber, 1996). For example, participants' ratings suggested they were no less interested in working with clients with BPD than those with depression or schizophrenia.

In this study, professional experience did not have an overall notable effect on responses to the vignettes. However, the researchers also investigated CPs' emotional reactions within treatment in general (without enquiring about any particular client group) through their 'Experience and Attitude Scale' designed for the study, and found that students, 'interns' and 'ABDs' (those who have completed all training requirements except their dissertations) reported being more inclined to regret saying things to clients, felt that their emotions were too powerful, occurred too often, and should be defended against, and believed that with more experience they would not have such strong emotional reactions to clients (Brody & Farber, 1996). This suggests that more experienced therapists feel more comfortable with their emotional reactions to clients, and are less likely to feel that such reactions are inappropriate or disruptive to treatment (Brody & Farber, 1996).

It should be noted that Brody & Farber's (1996) study was with a US sample, and therefore may not be generalisable to CPs in the UK. Furthermore, as with the above quantitative studies, the findings reflected participants' reactions to vignettes, rather than real clients seen in real clinical settings (Brody & Farber, 1996), which potentially reduces the ecological validity of the findings.

In a recent US study investigating CPs' perceptions of people with 'mental illness', Servais & Saunders (2007) asked CPs to rate the effectiveness, understandability, safety, worthiness, desirability, and similarity (to the rater) of people with BPD, schizophrenia, and moderate depression. The results indicated that CPs perceived the three client groups as different from themselves in terms of the above characteristics. In line with the evidence for negative perceptions of clients with BPD amongst CMs (Nehls, 2000), nursing staff (e.g. Markham, 2003) and CPs (Brody & Farber, 1996), a person with BPD was rated as the least safe, the least worthy, and the least desirable of the three clinical targets. The authors argue that the findings highlight the importance of tackling such negative attitudes at an individual and professional level (Servais & Saunders, 2007). This was also a quantitative vignette study however, again limiting its ecological validity.

Therefore, although there appears to be an evidence base for largely negative attitudes towards clients with BPD within staff, and an albeit small evidence base for this specifically within CPs, to date there has been no reported study exploring the attitudes of CPs towards clients with BPD in a UK setting. In addition, to date there appears to be no reported studies applying a qualitative methodology to the exploration of such attitudes in CPs, regarding their ‘real-life’ experiences of clients with BPD.

1.4.1 The Role of Staff Perceptions in Care-Giving

For clients with BPD, the therapeutic relationship is critical. This can be understood in terms of attachment theory (see Bowlby, 1988). It has been argued that in individuals with BPD, as a consequence of early traumatic childhood experiences, the attachment system has become oversensitive to separation and loss (Sable, 1997). According to this theory, there is a lack of coherence in the working models (i.e. sets of assumptions about ourselves and our competencies, and how others will relate to us) of people with BPD, particularly in interpersonal relationships and emotional regulation. BPD can be conceptualised as a disorder of intensely insecure attachment, with extreme oscillations between attachment and detachment. In this sense, people with BPD crave for a secure base but are scared to let themselves become attached to others, due to experiences of being rejected or abandoned. According to Sable (1997), it is this conflict that explains the oscillations in emotions and behaviour in BPD. Indeed, research has found increased rates of insecure attachment in clients with BPD compared to clients with depression (Patrick *et al.*, 1994).

From this perspective, the purpose of the therapeutic relationship is to provide a secure base and to modulate anxiety. The therapist may be regarded as providing a temporary attachment figure for the client (Adshead, 1998). Through the therapeutic relationship secure attachment will be facilitated through accurate, sensitive, and appropriately balanced responding to distress (Adshead, 1998). In line with this view, a review of the evidence for effectiveness of psychotherapeutic treatments for

PDs suggests that the encouragement of a powerful attachment relationship between client and therapist is a common feature of treatments shown to be moderately effective (Bateman & Fonagy, 2000).

There are several ways in which staff perceptions may affect the therapeutic relationship. When faced with stress, health care professionals may develop maladaptive interpersonal strategies with clients, which can take the form of dismissing the client's distress (Adshead, 1998). Research has demonstrated that providing services with a lack of concern means that clinicians and clients do not experience the perspective that only genuine care evokes (e.g. Nehls, 1994). When challenging behaviour is perceived as volitional and intractable, a sense of hopelessness about the effectiveness of intervention prevails (Nehls, 1998). Servais & Saunders (2007) emphasise that such negative perceptions may prevent the clinician from being able to display empathy and genuine concern for clients, and may also discourage the efforts of clients to make progress in therapy. Furthermore, Adshead (1998) highlights that dismissing a client's needs can lead to anger, which amplifies a desire to reject clients perceived as 'troublesome'. Therapists may then feel overwhelmed by such emotions, and may act them out in an overtly unhelpful manner, or more frequently, in a covert form, such as rigidly enforcing a contract (Adshead, 1998). Undoubtedly, these factors could all compromise the therapeutic relationship.

The role of countertransference (Freud, 1910/1957), adds another dimension to the importance of staff perceptions in care-giving. Psychoanalysts now recognise that such therapist reactions to the client, if correctly used, can facilitate rather than impede treatment (Betan *et al.*, 2005). When the client unconsciously attempts to elicit cognitions, affects, impulses and experiences similar to his/her own in the therapist, these projections can lead to trial identifications in the therapist, which are either complementary (i.e. the client and therapist temporarily take on complementary parts of the client's working models of his or herself and others) or concordant (i.e. the therapist experiences similar feelings to the client) (Fraser & Gallop, 1993). In order to be empathic, the therapist needs to be aware of the origin

of this countertransference, attend to the subjective experience of the client, and process the feelings without feeling under threat (Fraser & Gallop, 1993). Such processes are said to be critical to the eventual outcome of interactions with clients with BPD, yet perceptions of the BPD diagnosis can influence the ability of a therapist to engage in them (Fraser & Gallop, 1993).

In contrast to the dangers of dismissing clients' needs, Markham & Trower (2003) highlight the cautions of staff making attributions that they are responsible for solving their clients' problems. It has been suggested by Main (1957) that clients with BPD want others to be responsible for their emotional pain. If this is then accepted it creates enormous responsibility in staff (Markham & Trower, 2003) and can lead to 'burnout' (Brickman *et al.*, 1982). Over-involved therapists may also find it difficult to keep within the boundaries of the therapeutic relationship, or to allow their clients to improve and regain independence (Adshead, 1998).

Indeed, negative perceptions may influence treatment decisions and weaken the effectiveness of treatment (see Servais & Saunders, 2007). Furthermore, the stigma of BPD may be perpetuated by mental health professionals with negative perceptions failing to challenge misconceptions of PD, and modelling inappropriate behaviour (Servais & Saunders, 2007).

1.5 Study Rationale

Undoubtedly there are many controversies and uncertainties surrounding the concept of BPD. However, there is promising evidence of effective interventions for this client group (e.g. Davidson *et al.*, 2006), and evidence that people with BPD value their contact with mental health services, albeit if they encounter negative experiences and attitudes in such contacts (e.g. Fallon, 2003). Despite this, there is ample evidence of negative perceptions of clients with BPD amongst mental health professionals (e.g. Markham & Trower, 2003). There has been some investigation of perceptions of clients with BPD amongst CPs (Brody & Farber, 1996; Servais &

Saunders, 2007), but the two reported studies investigating this have been in the US, and have used quantitative methodologies only. The views of CPs are particularly important, as CPs are expected to take a self-critical approach to their work, continuously striving to increase the quality of services (Servais & Saunders, 2007). Moreover, given the current BPS recommendation that CPs should become clinical leaders in this area (Alwin *et al.*, 2006), and evidence which suggests that staff perceptions not only have the potential to compromise the therapeutic relationship, inhibit the effectiveness of treatment, and lead to 'burnout' in staff, but also perpetuate the stigma of BPD amongst others, it is imperative that the perceptions of CPs are explored in anticipation of this new role for the profession.

Given the additional evidence which suggests that nurses' and CPs' negative perceptions of clients with BPD do not improve with experience (Brody & Farber, 1996; Markham, 2003), it is also of interest to note any differences in perceptions which emerge between CPs at different stages in their careers. This is important because it may suggest whether training, knowledge, or other possible factors that are different for CPs at different stages in their careers, serve to reduce stigma associated with BPD.

1.5.1 Qualitative Evaluation

While quantitative research generally seeks to provide quantified answers to research questions, such as 'How many Xs are there?' in experimental settings, qualitative research seeks to explore questions such as 'What is X and how does X vary in different circumstances, and why?' (Pope & Mays, 1995). Thus, while CPs' views of clients with BPD have been compared with their views of clients with other diagnoses along scales stating examples of perceptions that were predefined by the researchers (Brody & Farber, 1996; Servais & Saunders, 2007), the current study will use a more open method of analysis. In using a qualitative approach one does not define 'variables' before the research process commences, as this would prevent the identification of participants' own ways of making sense of the phenomenon under study (Willig, 2001). With research on CPs' experiences and perceptions of clients with BPD clearly in its infancy, and indeed, with no such research having been

conducted in the UK at all, the more exploratory nature of a qualitative approach is most appropriate.

Pope & Mays (1995) contend that qualitative approaches can explore areas that are not amenable to quantitative research, such as the views of professionals in health services in times of policy change. As such, a qualitative approach to the present study would seem most apt, given the recent recommendations by the BPS regarding the role of CPs in this area in response to new government policy. Furthermore, in the quantitative studies already conducted, we do not learn about the actual experiences that participants have encountered with clients, which may add more depth to their reported perceptions. Using a qualitative approach, which allows real-life experiences in the NHS to be explored, is likely to increase the ecological validity of the study.

A further advantage of a qualitative approach is that it can help us to understand social phenomena in natural settings, giving the views, meanings and experiences of all the participants due emphasis (Pope & Mays, 1995). Therefore, it is hoped that the use of such an approach will enable the perspectives of all those who participate to be represented, including those that do not reflect the majority.

It is anticipated that using a qualitative approach to explore CPs' experiences and perceptions of clients with BPD will reveal how CPs have experienced clients with BPD, how they feel about working with them, and how they perceive their role in the area. In turn, this may generate ideas or hypotheses for future empirical study.

1.6 Aims

Primary aim:

- To explore CPs' experiences and perceptions of clients with BPD

Secondary aim:

- To tentatively note any differences in the experiences and perceptions of CPs at different stages in their careers

2. METHOD

2.1 Design

A qualitative design, based on the principles of interpretative phenomenological analysis (IPA) (Smith, 1996) (see section 2.5.1) and the focus group (FG) method, which involves engaging a small number of participants in an informal group discussion focused on a particular subject, were used.

IPA is more commonly used with individual interviews, as it has been developed as an approach committed to the detailed exploration of personal experience (Smith, 2004). However, it has been argued that FGs actually place a greater emphasis on the participants' points of view, as the interviewer has less interaction with the participants (Morgan, 1988). It has, on the other hand, been suggested that the expression of group norms may suppress individual articulation of dissent, and that confidentiality may be compromised due to the presence of others. Yet, if this does occur, it can provide a valuable insight into people's experiences. For instance, in an example of a study with older people in residential care, provided by Kitzinger (1995), a fear of being 'punished' for 'being cheeky' was demonstrated. Moreover, Kitzinger (1995) contends that instead of people feeling inhibited by the group, conversely, FGs can facilitate the discussion of controversial subjects (of which BPD is one), as the more confident participants 'break the ice' for shyer group members. Group situations can relax peoples' inhibitions and increase candour (Krueger, 1994). Furthermore, group members can offer support in expressing views that are prevalent in their group but which they regard to be deviant from mainstream culture (Kitzinger, 1995). This advantage of the FG suggests that it is particularly suited to exploring personal experience.

It has also been suggested that in a focus group study, the researcher will never discover how the participants would have responded had they been interviewed individually. Yet this criticism could equally be aimed at individual interviews, as one does not discover how the participants would have responded had they been

interviewed in a group setting (Morgan, 1988). Indeed, a FG is less artificial than a one-to-one interview, as it is a socially oriented procedure, and people are social creatures, who interact with each other (Krueger, 1994). This increases the likely ecological validity of such data (Willig, 2001). People are influenced by the comments of others and make decisions after listening to the advice and counsel of those around them. Unlike FGs, one-to-one interviews cannot capture such group dynamics (Krueger, 1994). Again, this suggests that FGs may actually tap deeper into personal experience by acknowledging the role of social interaction in such experience. In fact, some recent studies have successfully amalgamated the FG with an IPA approach (e.g. Jordan *et al.*, 2007), and Smith (2004) declares that the use of FGs for IPA is ‘an area ripe for exploration’ (p.50).

There are additional benefits to the use of FGs. For example, participants can be empowered through developing particular perspectives as a result of sharing experiences with other people who have had similar experiences (e.g. moving from self-blaming explanations to structural solutions), and the expression of criticism and the exploration of different solutions can be facilitated by the group setting (Kitzinger, 1995). Thus, the suitability of FGs to exploring personal experience as aimed for in IPA, and the possibilities of how FGs can lead to new ideas, and improvements to services, deemed the FG the most suitable method for collecting data in the present study.

2.2 Participants

As recommended for both IPA (Smith & Osborn, 2003) and FG studies (Cote-Arsenault & Morrison-Beedy, 1999), purposive sampling was used, meaning that participants selected were fairly homogeneous, rather than a random or representative sample. Inclusion and exclusion criteria are outlined in Appendix II. Exclusion criteria were required as the study was exploring CPs’ experiences and perceptions of clients with BPD within adult mental health services, and such experiences and perceptions may vary from those within services for other client

populations. Furthermore, including participants who work within other specialities would add more heterogeneity to the sample. Similarly, the perspectives of CPs who are ‘experts’ in the area of BPD (for example, CPs working in specialist services for clients with BPD, or CPs who specialise in specific interventions for BPD, such as DBT) may also have varied from those who are ‘non-experts’ in the area. Thus, while participants who work, or have worked in community mental health teams (CMHTs) were included, as they were thought to have been likely to have considerable experience in working with clients with BPD, the researcher did not seek to recruit a sample of ‘experts’ in the field of BPD. Such a sample may have reported different experiences and perceptions of this client group.

2.2.1 Group Composition

All participants were from the same health board area. Such ‘naturally occurring’ groups have several advantages. For example, they allow the observation of fragments of interactions that may be similar to naturally occurring data (Kitzinger, 1995). However, Kitzinger (1995) warns that some participants may feel inhibited due to any hierarchy within the group. Therefore, trainees were organised into separate FGs from fully qualified CPs.

A total of 16 participants took part in the study. Each participant took part in one FG. A total of four groups were conducted. Limiting the size of each FG to four or five is said to enable each participant to fully tell his or her story (Cote-Arsenault & Morrison-Beedy, 1999). Therefore, the first group conducted was a pilot group comprising of five trainees. The remaining three groups were the study groups. The second group comprised of four trainees, the third group comprised of three newly qualified CPs, and the fourth group comprised of four more experienced CPs.

All participants were female. Stages in participants’ careers ranged from the first year on the Doctorate in Clinical Psychology training course, to 32 years post qualification.

2.3 Procedure

2.3.1 Recruitment

The recruitment process began in January 2007. Naturally occurring groups of trainee CPs and fully qualified CPs were identified and approached by letter (see Appendix III). This invitational letter was sent to 23 potential participants. Within three days the researcher contacted them to ask if they were interested in participating. All potential participants who were either spoken to or replied by email said they were interested in participating. This was a total of 20 psychologists. Those who expressed an interest were sent an information sheet (see Appendix IV) providing further details on the study, and they were encouraged to ask any questions they may have had. The interested participants were also sent a consent form (see Appendix V) outlining, for example, that they agreed to respect other participants' confidentiality. These were later counter-signed by the researcher at the beginning of the FGs.

By February 2007, a total of 20 participants had agreed to take part in the study, (a 87 per cent response rate). However, four of these interested participants were not available to participate at the times that suited the majority. Thus, in the end, 16 (70 per cent of the total number of potential participants approached) were arranged into four separate FGs.

2.3.2 Data Collection

2.3.2.1 Focus Group Interviews

A pilot group was conducted to reflect on the wording and sequence of the questions, the researcher's responses used to encourage participant responses, the room arrangement and the composition of the participants (Krueger, 1994). As no changes were required, the pilot data was also used in the analysis.

All FG sessions were held during February 2007. They were conducted in a private meeting room in the clinical psychology department, which was a natural setting, and convenient for the participants. The duration of the FGs ranged from 68 to 88

minutes, with a mean of 79 minutes. Participants and the researcher (who conducted all FGs) sat in comfortable seats arranged in a circle.

Each session began by the researcher welcoming the participants and reiterating confidentiality issues. For example, participants were asked not to use real names if referring to clients. The researcher then went on to provide the group with an overview of the FG process and ground rules, as recommended by Morgan (1988). For example, participants were advised to discuss the questions naturally, and as a group, rather than answering the researcher directly. They were asked to encourage each person to participate, as it was stressed that the researcher was interested in each person's experiences and perceptions. It was also requested that the participants were honest, as there were no right or wrong answers. Participants were encouraged to tell the group about their own experiences even if they felt they were the same as the others' (Morgan, 1988).

2.3.2.2 Interview Guide

A semi-structured interview schedule (see Appendix VI) was used. It was constructed as a guide only, and was based on recommendations for constructing questions suitable for FGs (see Krueger, 1994) and IPA (e.e. Smith & Osborn, 2003). One question ('Think back and tell us about a situation that you have experienced as a clinical psychologist with a client with borderline personality disorder – one that really stands out in your mind?') was based on that used by Nehls (2000).

The schedule incorporated a logical flow of questions, which were open enough to allow a variety of viewpoints to be expressed, and issues to spontaneously emerge. Additionally, the ordering of questions was not critical, the interviewer was free to probe interesting areas that arose, and the interview could follow the concerns of the participants (Smith & Osborn, 2003; Wilkinson, 2003). In this way, while the researcher had an idea of the area of interest and some questions to explore, there was also a desire to enter the psychological and social world of the participant, as much as this was possible (Smith & Osborn, 2003).

Another important aspect of the construction of the interview questions was that of ‘funnelling’. In this process, by beginning the sequence of questions with open questions and asking any more specific questions following this, participants are able to give their own view before being ‘funnelled’ into specific questions (Smith & Osborn, 2003). Therefore, the more specific questions, (e.g. ‘Tell us about your role in the area of BPD’) were asked towards the end of the schedule. However, if the participants addressed such issues earlier on in the interview, these questions were not repeated again at the end.

The phrase ‘think back’ was used at the beginning of several questions, to help place participants back in the original environment, instead of the immediate experience of being in the FG. This focus on the past increases the reliability of responses (Krueger, 1994).

2.3.2.3 Researcher Involvement in the Focus Group

As Kitzinger (1995) recommends in FGs, the researcher initially took a ‘backseat’, and engaged in what can be described as ‘structured eavesdropping’, while later in the session intervening more. Therefore, the researcher restricted head-nodding and used only value-neutral gestures. However, to help solicit further information when comments were vague (Krueger, 1994), and encourage participants to continue when entering interesting areas (Smith & Osborn, 2003), several ‘probes’ were used, as were phrases to encourage each participant to express their views, including those that may be different from others (see Appendix VI).

The researcher also used the ‘5-second pause’ (Krueger, 1994), to prompt additional views or agreement from participants following a participant comment. ‘Prompts’ (see Appendix VI) were also used on the odd occasion that the initial question was insufficient to elicit a satisfactory response from a particular participant (Smith & Osborn, 2003).

2.3.2.4 Ending the Sessions

Data redundancy and participant fatigue were factors considered in closing the FG sessions (Cote-Arsenault & Morrison-Beedy, 1999). At the end of the session, the researcher offered the participants thanks for their time and contribution, and provided time for de-briefing. Finally, the importance of keeping the experiences and perceptions of all participants confidential was reiterated.

2.4 Data Management

Digital recorders were used to audio-record the FG sessions. In order to minimise the risk of recording failure, two digital recorders were used in each group. As another backup, the interviewer took written notes on the discussion throughout the session. Field-notes were also made on non-verbal communication, such as nodding. This is important to note as it adds emphasis to the related discussion topic (Finch & Lewis, 2003). At the end of each session, the researcher made notes on her general impression of the interview, for example, how she felt the participants responded. Immediately after each FG was recorded, it was saved in a confidential file on a USB flash drive.

The recordings were then transcribed verbatim by the researcher. The corresponding observations from the field-notes were amalgamated into the transcriptions throughout. Although time consuming, personally transcribing the data allowed the researcher to immerse herself in it, and helped preserve confidentiality. As recommended by Smith & Osborn (2003), while transcription was generally at the semantic level, whereby all the words spoken were transcribed, other features, such as laughs, were also transcribed. To check the accuracy of the transcription, the researcher listened through the recordings whilst reading the transcripts, making corrections as necessary. The completed transcripts were saved as rich-text documents and imported onto NVivo (©1999-2002 QSR International Pty. Ltd). This is a software package which aids the management of large amounts of qualitative data.

2.5 Data Analysis

2.5.1 Method of Analysis

Phenomenology is a school of philosophical thought concerned with how humans gain knowledge of the world around them. It stresses that certain ways of gaining knowledge may be more constructive than others (Willig, 2001). According to phenomenology, the world can only be understood in terms of people's different perceptions of it, rather than by any objective description of events or objects per se. Within psychological research, phenomenology focuses on participants' perspectives of their world, and can be used to study any form of human experience (Willig, 2001). IPA (Smith, 1996) is a form of phenomenology which accepts the impossibility of gaining access to participants' life worlds (Willig, 2001). It is phenomenological, as it attempts to study the participants' experience of an object or event from his or her perspective, rather than attempting to produce an objective account of the object or event itself. Yet, it is interpretative, in that it recognises the necessary implications of the researcher's own view of the world, and the nature of the interaction between the researcher and participant, on this exploration.

This two-stage interpretation process where participants try to make sense of their world, and the researcher tries to make sense of the participants trying to make sense of their world (Smith & Osborn, 2003) is reflective of IPA's connection to hermeneutics (Ricoeur, 1970). IPA combines empathic hermeneutics and questioning hermeneutics, in that it 'takes the side' of the participants, but also asks critical questions of their texts, such as, whether something is 'leaking out' unintentionally (Smith & Osborn, 2003). Thus, IPA is also related to symbolic interactionism (Denzin, 1995), a sociological stance, which contends that the meanings people assign to events and objects are the result of interactions between actors in the social world. In this way, IPA recognises that people's interpretations are not fully idiosyncratic, but related to social interactions and shared social processes (Willig, 2001). Yet, IPA is a distinctively psychological research method,

which aims to gain insight into individual participants' psychological worlds, and is concerned with the nature or essence of phenomena, rather than what accounts for such phenomena (Willig, 2001).

Therefore, IPA was chosen for the present study, due to appearing to be the most appropriate method for attempting to understand participants' experiences of clients with BPD and how they make sense of such experiences. Given that stigma surrounding BPD has been uncovered in previous research (see section 1.4), IPA seemed appropriate for exploring the participants' personal perceptions of clients with BPD without trying to produce an objective account of this client group. The double hermeneutic of taking an empathic yet questioning stance in the analysis in this approach also appeared appropriate for this purpose. As IPA pays some acknowledgement to symbolic interactionism, this also seemed particularly suited to the social setting of the FG.

The acceptance that IPA gives to the significant role of the researcher was also considered appealing, as being a trainee CP, the researcher was a member of the same profession being studied. Therefore, the researcher's reflections might add a further dimension to the topic being explored. The researcher was also a colleague of those who participated, which could arguably have had an influence on the discussions in the FGs. In addition, the researcher had worked as a research assistant on a RCT of CBT for clients with BPD (Davidson *et al.*, 2006), which involved spending considerable time interviewing over 40 individuals with BPD. As such, she was likely to have formed her own perceptions of this client group. Due to such factors concerning the researcher, her own thoughts and feelings on conducting the research were viewed as an important aspect of the study.

2.5.2 Process of Analysis

A participant based group analysis (Ritchie *et al.*, 2003) was conducted. This involved the contributions of individual participants being separately analysed within the context of the group discussion as a whole, allowing the accounts of each

participant to be retained, while interactions between participants were analysed as part of the group dynamic.

Smith (2004) advises that when using IPA to analyse FG data, one should ‘parse’ transcripts at least once for group dynamics and patterns and once for individual accounts, to check whether participants appear to be able to discuss personal experiences with an adequate amount of description and intimacy. Following this procedure (which indeed revealed that all participants spoke about their own experiences and raised issues spontaneously, and that differing as well as common views were expressed), the researcher was convinced that despite the presence of other group members, the participants’ accounts appeared to fulfil this requirement.

To conduct the IPA analysis of individual narratives, the researcher followed the step-by-step approach outlined by Smith & Osborn (2003) (see Figure 1).

Figure 1: Step-by-Step Analysis Procedure (Individual Narratives)

Step 1: One participant's account (from the first FG) was read several times, in order to become as familiar as possible with it. While reading it, the left margin of the transcript was used to summarise or paraphrase, comment on the use of language, note anything interesting, and make associations and preliminary interpretations about what the participant said. The whole of the first account was approached in this way.



Step 2: Returning to the start of the first account, the right hand margin of the transcript was used to note any emerging themes. The challenge at this stage was to think of terms that were at a high enough level of abstraction to enable theoretical links across and within participant accounts to be made, but also still grounded in what was actually said in that particular excerpt. This process was continued until the end of the account, with the same theme labels being used when similar themes emerged.



Step 3: A list of emergent themes was made, and connections between them were looked for. Some themes clustered together due to sharing references or meanings, and others appeared to be superordinate themes (i.e. themes which captured the essence of a cluster of themes). The researcher moved back and forth between the clusters of themes and the transcript, checking that the connections being made still made sense in relation to the transcript.



Step 4: A clearly structured table of the superordinate themes and their corresponding sub-themes was compiled. An identifier was added to each theme. This comprised of an example of key words from the transcript, which were related to the corresponding theme, and the page and line number of the example. This facilitated the retrieval of the original source for later in the organisation of the analysis. During this process, some themes were abandoned, due to a lack of rich evidence in the transcript.



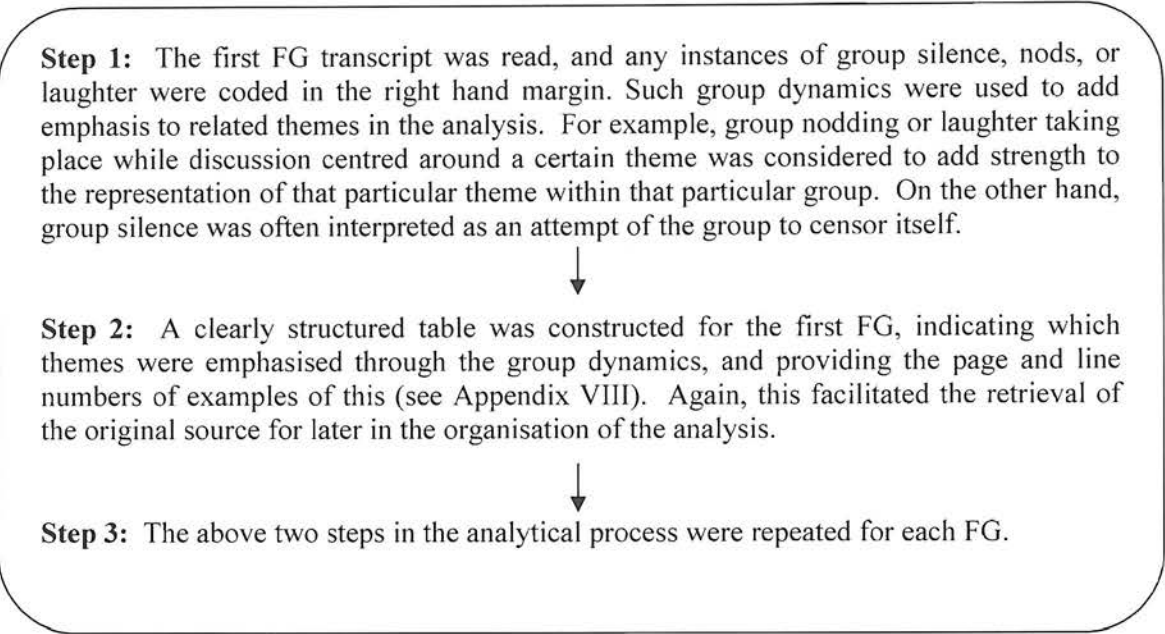
Step 5: The themes from the first case were used to help orient the coding of the other cases. In this process, new themes were coded as well as repeated ones, to ensure that similarities and differences between participants' accounts were recognised. The method for interpreting an account described above was conducted with each case. In keeping with the cyclical process, any new themes were checked against earlier accounts, to determine whether such themes were actually new themes, or merely new manifestations of earlier themes. In addition, the earlier accounts were checked to ensure prior manifestations of the new themes had not been ignored.



Step 6: A progressively integrated list of themes was developed, which was complete after the analysis of the 16th participant. This list was displayed in final clearly structured tables regarding each participant (see Appendix VII).

Following this, as based on recommendations by Kitzinger (1995), special categories were coded to take account of group factors. This process is outlined in Figure 2.

Figure 2: Step-by-Step Analysis Procedure (Group Factors)



Another way in which group factors were taken into account was in deciding on what themes were emerging in the analysis of individual narratives. In other words, some themes were not only coded according to what the participant said (i.e. the content), but also according to the group process that was occurring. For example, when a participant was spontaneously asking other participants about their experiences, this was coded under the sub-theme of ‘desire to learn more’ (see section 3.3.8.1).

2.6 Validity and Quality

While validity and quality are certainly important factors to consider in evaluating any research, traditional criteria for evaluating the quality of research in psychology are not suitable for qualitative research (Smith, 2003; Yardley, 2000). For example, as the purpose of qualitative research is to provide just one of several possible ways of interpreting data, reliability and replicability appear inappropriate. Therefore, the researcher utilised the aptly open-ended and flexible criteria for assessing quality in qualitative research, proposed by Yardley (2000). These criteria cover the three broad dimensions of ‘sensitivity to context’, ‘commitment, rigour, transparency and coherence’, and ‘impact and importance’.

2.6.1 Sensitivity to Context

Through showing an awareness of the background literature, including studies that have investigated similar topics (e.g. Servais & Saunders, 2007) and those that have employed similar methods (e.g. Jordan *et al.*, 2005), and endeavouring to link the current data to the findings of other studies, the researcher enhanced her sensitivity to the contexts of theory and previous literature.

The researcher also became sensitive to the social context of the relationship between herself and the participants. While the researcher attempted to minimise the imposition of her previous knowledge of the area on the FG process (through the use of open-ended questions and a low level of involvement in the session), she was aware of the possible effects of being a colleague and member of the same profession as the participants. For example, the researcher alerted herself to the possibility that the participants may have been attempting to say what they felt would be expected of the profession.

Similarly, the researcher was mindful of the likely effects of the social context of the group, such as more experienced staff being in the same group as those with less experience, and the possible hierarchical issues this may have raised. While being sensitive to this possibility led the researcher to design the groups according to the

stages in the careers of participants, there were still variances in stages in careers within these groups. As such, when the researcher interpreted the participants' accounts, such factors were kept in mind. For example, the social context was used as a way of gaining an extra insight into what the participants regarded to be acceptable to say.

2.6.2 Commitment, Rigour, Transparency and Coherence

In line with the criterion 'commitment', the researcher had been developing knowledge and experience in the topic of clients with BPD since working on the RCT with this client group (Davidson *et al.*, 2006) four years prior to beginning the study. She had also strived to conduct a comprehensive, up-to-date review of the literature in this area. In addition to extensive reading on the methods of IPA and FGs, the researcher attended an IPA training day. This gave the researcher the valuable opportunity to engage in role-plays of IPA interviews prior to conducting her own research. To enhance her commitment further, the researcher transcribed the FGs, allowing her to become immersed in the data.

'Rigour' was enhanced through using FGs to interview as large a sample of both trainees and fully qualified CPs as considered possible to analyse at the in-depth level required for IPA, and within the given time constraints of the study. The completeness of the interpretation was also enhanced by, for example, the cyclical process of constantly checking new themes against earlier participants' accounts. Rigour was also upheld by ensuring that all themes were generated from the data itself, and not forced into any predefined themes. To ensure this process was carried out as rigorously as possible, all data was analysed manually using the guidance of Smith & Osborn (2003), before being systematically categorised on NVivo, which then allowed the quick retrieval of data files. This removed the need for physical cutting and pasting, hence allowing the researcher more time for the thinking and reflecting which is critical to the analysis.

'Transparency' was enhanced by the researcher providing a detailed description of how data was collected and analysed. To illustrate the coding process further, a

coded excerpt is included in the appendices (see Appendix IX). Yardley (2000) argues that it is important to reflect openly on how the researcher's own experiences and perceptions may have affected the product of the research. Thus, the researcher kept a reflexive diary throughout the study (see section 4.3).

To ensure that the 'coherence' criterion was met, the academic and clinical supervisors were provided with the coding framework tables and transcripts, to read through and check that the interpretations made by the researcher were convincing and plausible.

2.6.3 Impact and Importance

It was anticipated that sharing experiences and perceptions of clients with BPD within the FG forum would be likely to help the CPs and trainee CPs involved identify their own assumptions and possible difficulties in working with this group. As Yardley (2000) highlights, such research-in-context can mean that the link between research and clinical practice can become so close that they are combined. It was hoped that the FGs would, in this way, not only explore CPs' experiences and perceptions of this client group (which itself would be likely to lead to implications for practice), but also serve to create new solutions in this area. In this sense, the FGs could be seen as 'action research'.

2.7 Ethical Issues

To address potential concerns regarding the confidentiality and anonymity of the participants, a number of procedures were put in place. For example, only the researcher listened to the recordings, and she guaranteed the confidentiality of the discussion. In addition, participant agreement to protect the confidentiality of other group members was made explicit at the outset of the FGs. The groups were conducted sensitively and with regard for the safety and respect for the opinions of those involved. Having developed skills in handling sensitive discussions, and experience in running groups throughout the Doctorate in Clinical Psychology

training course, the researcher was considered capable of moderating the FGs in this way.

Although the discussions were audio-recorded, and participants were asked to state their names at the beginning of the recordings, each participant was allocated a participant identification number (PIN). As such, the transcripts did not contain the participants' names, but contained the PINs. Immediately after each FG was recorded, it was saved in a confidential file on a USB flash drive and erased from the digital recorders. Although the supervisors also read the transcripts, participants were anonymous in these, as they were only referred to by their PINs.

The above information was all detailed clearly in a participant information sheet (see Appendix IV), which also provided further details on the study. Interested participants were given a fortnight to decide whether or not they wished to participate, to allow them enough time to make an informed choice before signing the consent form (see Appendix V).

Prior to beginning the research study, a favourable ethical opinion on the research proposal was given by the local research ethics committee (see Appendix X). Following this approval, research and development management approval from the local NHS board was also granted (see Appendix XI).

3. FINDINGS

All participants are referred to by their PINs. The first figure in the PIN refers to the number of the FG the participant took part in. The second figure was randomly allocated within each group. The researcher is referred to as ‘I’ (for interviewer).

3.1 Participant Background Information

Table 1: Background Information (FG 1)

Participant	Doctoral training year	Level of experience in BPD
1.1	3	worked with a few clients who met BPD criteria, including one with a diagnosis
1.2	1	unsure (no experience ‘as far as aware’)
1.3	1	no experience
1.4	3	worked with a few clients with ‘personality issues’, no one with a BPD diagnosis
1.5	2	unsure (thinks may have worked with a few clients who met BPD criteria)

Table 2: Background Information (FG 2)

Participant	Doctoral training year	Level of experience in BPD
2.1	2	no experience
2.2	4	worked with one client likely to have met BPD criteria but did not have a diagnosis
2.3	1	no experience
2.4	2	unsure (thinks may have worked with a few clients who met BPD criteria)

As displayed in Tables 1 and 2, some of the trainees reported having no experience with clients with BPD. Interestingly however, as the discussion in the FGs progressed, they began to wonder if they had indeed, worked with clients who may have met criteria for BPD, or presented with some BPD traits.

Table 3: Background Information (FG 3)

Participant	Years qualified	Settings worked in	Level of experience in BPD
3.1	2	primary care	worked with a ‘handful’ of cases, some who were likely to have met BPD criteria but did not have BPD diagnoses and some who had BPD diagnoses
3.2	2	primary care	worked with ‘three or four’ clients with BPD diagnoses
3.3	1	primary care	working with a client who is likely to meet BPD criteria, unsure if she has been diagnosed

Table 4: Background Information (FG 4)

Participant	Years qualified	Settings worked in	Level of experience in BPD
4.1	10	primary care/ CMHTs/ intensive home treatment team	worked with a few clients with BPD diagnoses
4.2	12	primary care/ CMHTs	worked with a few clients who were likely to have met BPD criteria but did not have BPD diagnoses and a few clients with BPD diagnoses
4.3	32	primary care/ CMHTs/ psychiatric rehab	worked with a few clients who were likely to have met BPD criteria but did not have BPD diagnoses and few clients with BPD diagnoses (unsure if worked with more clients with BPD earlier in career without realising at time)
4.4	8	primary care/ health/psychiatric rehab	worked with a few clients who were likely to have met BPD criteria



As displayed in Tables 1, 2, 3 and 4, within each group, it appeared that participants in later years of their training, or who were qualified for longer, reported having more experience in the area of BPD than those in their earlier years of training, or those qualified for a shorter time.

The issue in all groups (as shown in Tables 1, 2, 3 and 4), of participants being unsure if some clients they have worked with have had BPD or not, and reporting having worked with clients who are likely to have met the BPD criteria, but have not been diagnosed, will be referred to in sections 3.3.2.2 and 3.3.6.1, respectively. As shown in Table 4, one participant reported being unsure if she had worked with more clients with BPD earlier in her career without realising. This issue will be referred to in section 3.3.8.2.

3.2 Levels of Participation

All participants appeared to ‘tell their story’, and ask other participants questions. However, some participants appeared to contribute slightly more than others. For example, 1.1, 1.4, 2.4 and 3.1 appeared to spend more time talking about their experiences. Perhaps this was because they had more experience to discuss than the other participants in their groups. Yet, 2.2 reported to having had more direct experience of working in the area of BPD than the others in FG 2, and while she was not passive in her contributions, she contributed less than 2.4, who apparently had less experience. However, as mentioned above, 2.4 was unsure of how much experience she had in working with this client group, so perhaps she did have more experience to discuss than 2.2. Clearly there are other possible factors that may affect how much participants contribute to the conversation. For example, 2.2 may tend to be less talkative within groups than 2.4, or may have felt defensive over her experience in working with clients with BPD.

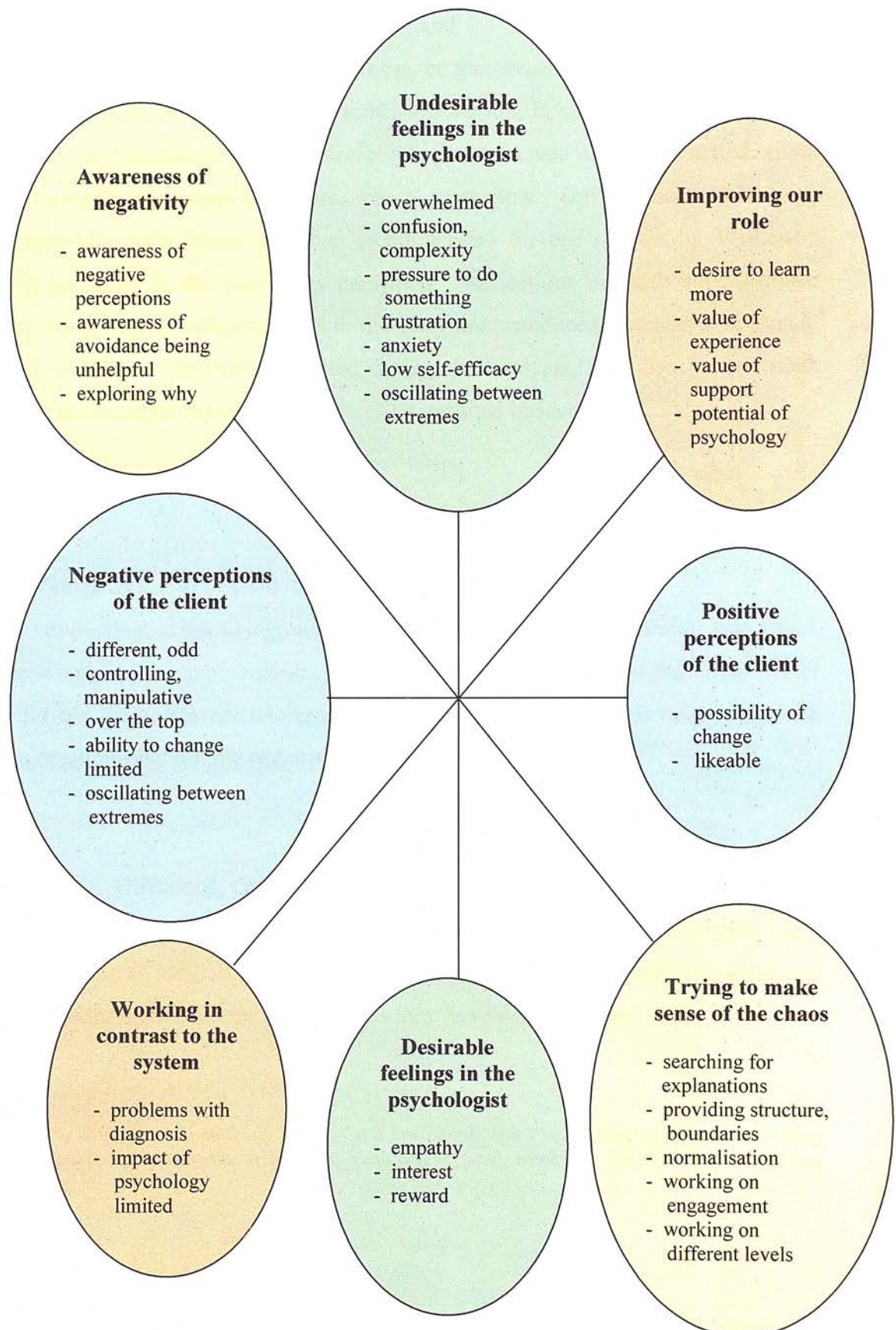
It appears that 1.2, 1.5, and 2.3 asked the most questions within groups. This may be related to these participants having less experience than some of the other group members, and therefore perhaps wanting to hear about others' experiences. This issue is discussed in section 3.3.8.1. However, it may also be attributed to some people tending to ask more questions than others within group settings.

Contributions to the group seemed particularly even for all members in FG 4. Perhaps this was due to the participants all having had a considerable amount of experience to discuss. As with the other groups, it appeared that individuals were able to construct their own narratives. This was evident as differing as well as common themes were expressed.

3.3 Themes

The eight superordinate themes of 'negative perceptions of the client', 'undesirable feelings in the psychologist', 'positive perceptions of the client', 'desirable feelings in the psychologist', 'trying to make sense of the chaos', 'working in contrast to the system', 'awareness of negativity', and 'improving our role' emerged from the analysis. Figure 3 illustrates these superordinate themes, along with their corresponding sub-themes. The themes are juxtaposed to highlight relationships between them, which are discussed further in section 3.4.

Figure 3: Identified Superordinate Themes and Sub-Themes Relating to Participants' Experiences and Perceptions of Clients with BPD



The majority of superordinate themes emerged from the narratives of all participants. Those that did not emerge in all participants' narratives ('positive perceptions of the client' and 'desirable feelings in the psychologist') were only absent from a minority of participants' accounts (1.2, 2.2 and 4.4, and 1.1 and 4.4, respectively). There appeared to be, however, more differences in the presence of sub-themes. Such differences will be referred to in the following section, in which each superordinate theme will be introduced, and its corresponding sub-themes will be presented, along with illustrative quotations from participants' transcripts. Transcription conventions (see Appendix XII), based on those recommended for use in FGs by Wilkinson (2003), are used in the quotations presented. Reflections on each superordinate theme, which involve referring back to the literature introduced throughout section 1, as well as further literature consulted during the analysis, will also be provided. Finally, relationships between themes will be outlined in section 3.4.

3.3.1 Negative Perceptions of the Client

While conducting, transcribing, and analysing the groups, the researcher was struck by the weight of the superordinate theme 'negative perceptions of the client'. Not only did this theme emerge within all groups and all participants, it was represented in rich detail throughout the narratives.

3.3.1.1 Different, Odd

All participants' narratives included manifestations of the theme of 'different, odd'. Some participants seemed to view clients with BPD as having something markedly different about them from the other clients they have worked with:

4.2: I think, I can certainly think of a, a few people that I've worked with, and I think they tend to stick out in your mind, [4.1: Yeah/laughs] yeah, you know, they kind of stick out in a way

Throughout, the use of language highlighted this view. Note in the following excerpt, for example, the emphasis on the word ‘they’ stresses how different 3.3 perceives the behaviour of clients with BPD compared to that of other clients:

3.3: ...when they miss appointments they really are communicating something

Several participants went so far as to convey clients with BPD being different in an ‘odd’ sense. This is illustrated in the somewhat non-conformist image of a client with BPD that 2.1 portrayed:

2.1: I just thought of somebody looking really kind of manic [laughs] and dishevelled and hair everywhere, [laughs] just a picture that came into my head and I don’t know, that was probably just my mind but just somebody really like, well somebody with a long skirt and big mad hair and.....

Group agreement on this theme was emphasised through the dynamics across all FGs. The following group joke in FG 1 illustrates the notion of ‘us and them’ particularly well:

1.3: I’m sure I read somewhere that 20 per cent of the population have some form of personality disorder so –
1.1/1.2/1.3/1.4/1.5: [laugh]
...
1.5: That’s worrying...It’s one of us! [laughs]
1.1/1.2/1.3/1.5/1: [laugh]
1.2: Well not that it was you [makes eye contact with 1.5] [1.1/1.2/1.3/1.4/1.5: laugh] but it might be someone in this room [laughs]
1.1/1.2/1.3/1.4/1.5: [laugh]
1.1: Well it’s definitely, if it’s 20 per cent it’s definitely one of us, might be even two! [laughs]
1.1/1.2/1.3/1.4/1.5: [laugh]

It is interesting to note that even the researcher joined in the group laughter at one point, indicating her own amusement at this joke, and hence strengthening the evidence for this theme even further.

3.3.1.2 Controlling, Manipulative

A sense of clients with BPD deliberately making the psychologists feel certain ways, or being demanding, was prevalent in many participants' narratives across all FGs:

1.1: It's I think it's even sometimes one step more than just the neediness but also kind of turning into blackmail [pause] you know if you're not, if that doesn't fit then this and this is going to happen to me, which can really, where you can feel the pressure when they say 'Oh well I'm gonna go hurt myself' [1.4: Yeah] or things like that.....

4.4: ...'Why can't I see you then?', and 'That's not convenient', and 'I can only come on a Tuesday at 11.30 and aren't you supposed to be helping me' [4.1/4.2/4.3: laugh] and 'That's the most convenient time I can come'

Some participants, again across all groups, explicitly described these clients as manipulative:

2.2: ...they kind of have, I have an image of them being quite manipulative [2.4: Mmm] and attention seeking and you can never quite be sure with the information generally, thinking if it was 100 per cent true, [2.4: Yeah] I think you've gotta be quite careful about that when assessing risk, how like if they're saying they took so many tablets, how true that actually is

The way in which 2.2 corrects herself and emphasises the word 'I' was a common occurrence in the narratives, and appeared to demonstrate an awareness of this being a negative perception. This issue will be discussed further in section 3.3.7.1.

Group agreement emphasised through the dynamics in FGs 2 and 4 also adds weight to the sub-theme of 'controlling, manipulative', as demonstrated in the apparently knowing laughter at 4.4's above impersonation of a client with BPD demanding to be seen at a certain time.

3.3.1.3 Over the Top

A sense of clients with BPD being ‘over the top’ was conveyed in the narratives of some participants, across all groups. Notably, the trainees who portrayed a sense of this theme were mainly those who had some experience with this client group. A few participants described clients as exaggerating, or over-reacting:

2.2: ...in crisis maybe not about something [stutters] that is major, or seems that major, [2.4: Mm] but having like massive overreactions [2.4: Mm] to something that’s quite small

2.4: ... you might be on holiday for a week and can’t see them [2.1: Yeah] you know that can be blown up [2.2: Mhm] into something much bigger quite easily

Language, such as the emphasis of the word ‘massive’ was used to convey a sense of how ‘over the top’ participants viewed clients with BPD.

Others portrayed an image of clients being ‘over the top’ in their presentation:

4.4: ...some of the people that I’ve seen have been very kind of flamboyant [4.2: Yeah] either kind of physically, [4.1: Mhm] in terms of when they walk in the room they’re like, wow, [laughs] [4.1/4.2/4.3: laugh] you know, hello, [4.3: Yes] [4.1: Uh huh] [4.2: Yeah] um, or even they come in and they just make statements [makes eye contact with 4.2] like you were saying earlier about the girl who came in and said ‘It all started when I was 16 [laughs] and I was charged with murder’

Group agreement within FGs 2 and 4 strengthened this theme. For example, note the knowing laughter and agreement of the whole group during 4.4’s portrayal of a flamboyant client.

3.3.1.4 Ability to Change Limited

Many participants, across all FGs, tended to convey an assumption that clients with BPD get ‘stuck’ after a certain stage in therapy:

1.5: ...it needs a lot of intensive work to try and help [pauses] help them to some extent

4.3: ...you can contain people but they don’t actually move, [4.4: Yeah] you know, [4.2: Yes] they don’t move on, so.....

Note how 1.5 corrects herself by saying ‘to some extent’, particularly highlighting this assumption. Some attributed the limitations to change to the client’s self-defeatism:

1.1: ...these people always end up in the worst situations, [1.5: Mhm] um, and they often do have a bad starting point but then you just think well this happened and then that and then that and some of those things you can actually, um, you can see coming [1.4: Mm] [1.5: Yeah] and people don’t seem to, they seem to have a kind of amazing ability to get into more troubles or.....

For others, ability to change was viewed as limited by social factors outside of therapy:

3.3: ...I guess there is a problem of that, that it is quite a distinctly different relationship to anything they’re going to have [3.2: Yeah] outside

It should be noted that 4.1 and 4.2, who had considerable experience in working with clients with BPD, did not convey this theme in their narratives. However, neither did 2.1, who had much less experience in the area.

3.3.1.5 Oscillating Between Extremes

An image of the BPD client as oscillating from one extreme to another, in terms of several aspects (for example, thinking, emotions and relationships) was conveyed in the accounts of most participants, across all groups:

2.1: ...she's very, very chaotic [2.2/2.3: nod] and eh one week, you know, you'll be the best person in the world and then the next week you'll be the worst person in the world, [2.2/2.4: nod] and even within sessions, one minute she can be laughing [laughs] and really happy, and the next minute in lots of tears

4.2: ...the world's good or bad

2.4: I just [laughs] my, I suppose my first, well idea or exposure to anything like, you know, borderline personality disorder, was em, you know this idea of 'bunny boiler' [2.2: Mhm] and you know, [laughs] Michael Douglas and Glenn Close [2.1/2.2/2.3: laugh] that kind of, you know real quite extreme stuff [2.1: Yeah] and this idea of people just being extremely clingly one moment [2.2: Mhm] so almost, you know, that if you're thinking about being in therapy with somebody that they want to see you all the time [2.1: Mhm] they could quite happily come back everyday, you know, you think about closing off the end of a session, that might be difficult [2.1: Yeah] [2.2: nods] em you know, the other side of that is they just don't want to see you at all...

The evidence for this theme was strengthened through the group dynamics in FG 2. For example, in the above illustration of the 'love-hate' aspect, group laughter mixed with signs of agreement adds weight to the theme.

3.3.1.6 Reflections on 'Negative Perceptions of the Client'

Negative perceptions of clients with BPD have been found in many previous studies with other professions (e.g. Nehls, 2000; Markham, 2003), as well as in quantitative research with CPs (Brody & Farber, 1996; Servais & Saunders, 2007). For example, Servais & Saunders' (2007) also indicate that CPs view clients with BPD as being 'different'. The authors emphasise the role of disidentification (a process one engages in whereby people with 'mental illness' are typified as clearly distinguishable from 'normal' individuals, whereas oneself is characterised as 'normal' and unsusceptible to 'mental illness') in the dynamic between CPs and their clients. They suggest that disidentification may operate to maintain self-esteem, or

to uphold CPs' perceptions of themselves in line with the social identity of being a mental health professional (Servais & Saunders', 2007). On the other hand, disidentification may indicate a wish to separate oneself psychologically from people with 'mental illness' (Servais & Saunders, 2007). It is possible that disidentification is also a process that the CPs in the present study engage in.

The emergence of the sub-theme 'controlling, manipulative' is also consistent with previous research with other professions (e.g. Markham & Trower, 2003; Nehls, 2000). As Markham & Trower (2003) point out, this is in contrast to theoretical literature, which suggests that clients with BPD have low self-efficacy beliefs, and as a result, view other people as controlling (Gabbard, 1989). The sub-theme 'ability to change limited' is also in line with the lack of optimism towards clients with BPD found in nursing staff (Markham & Trower, 2003) and could even be argued to be reminiscent of the historical view of BPD being untreatable (Alwin *et al.*, 2006).

While staff perceptions of clients oscillating between extremes has not been reported in previous research, this finding is important, as it fits with the literature on attachment theory. Specifically, it may lend support to Sable's (1997) theory that BPD is a disorder of intensely insecure attachment, with extreme vacillations between attachment and detachment. While perceptions of clients with BPD being 'over the top' have not specifically been mentioned in previous literature, they are consistent with the previously reported perceptions that these clients are less 'worthy' (Servais & Saunders, 2007), or less deserving of care (Lewis & Appleby, 1988).

Some differences in the emergence of the sub-themes of 'negative perceptions of the client' were identified. As the sub-theme of 'over the top' was mainly represented in the narratives of those who have had experience in working with clients with BPD, it may be that this is a perception that arises through such direct experience itself. Likewise, the sub-theme of 'ability to change limited', was absent from those who had a considerable amount of experience in the area, suggesting that their experience has led them to think differently about change in this client group. Yet, experience

of working with clients with BPD may not be necessary for CPs not to view change being limited, as this sub-theme was also absent from a participant with less experience.

Essentially, all participants expressed negative perceptions of clients with BPD regardless of the stage in their career, suggesting that while there may be some differences in the particular sub-themes present between the participants at different stages in their careers, factors related to being at a later career stage have not reduced the overall negative perceptions of clients with BPD for this group of CPs. This is in line with the findings from Markham's (2003) study with nursing staff, and Brody & Farber's (1996) study with CPs in the US.

3.3.2 Undesirable Feelings in the Psychologist

Another superordinate theme that emerged within all groups and all participants, and was represented in rich detail throughout, was that of 'undesirable feelings in the psychologist'. The participants continually attributed such feelings to the effect of clients with BPD.

3.3.2.1 Overwhelmed

A sense of feeling overwhelmed by clients with BPD was expressed by several participants, across all groups:

1.1: ...just standing in front of this whole, you know, mountain of chaos

3.2: ...it's like you feel like you're being thrown in the deep-end when you qualify because all of a sudden [stutters] there's no, there's no selection, you just see everyone and you sometimes get bombarded...

The use of metaphor in the above excerpts illustrates the feeling that clients with BPD could metaphorically drown the psychologist, or that they are ‘bombarded’ by having to deal with more than they feel one therapist can cope with.

The presence of the sub-theme ‘overwhelmed’ was strengthened by the group dynamics in FGs 1 and 4. For example, the whole group nodded in agreement at 1.4’s expression of how she feels overwhelmed after seeing her client:

1.4: It can take quite a lot of effort in the session and you always feel, well I always feel quite drained afterwards
1.5/1.3/1.2/1.1: [nod]

3.3.2.2 Confusion, Complexity

A sense of feeling confused on various levels, and that working with clients with BPD is very challenging, was conveyed in the narratives of all participants, across all groups. For some, the confusion was simply in relation to whether or not they had worked with anyone with BPD:

1.5: ...I think it was more to do with their kinda emotion regulation and it was to give them sort of help in dealing with things em that, that was coming up, em but in saying that they might’ve had borderline personality disorder I don’t know

Some were confused about what to actually do in their work with clients with BPD:

3.3: ‘...what can I do, where do I start?’ [3.2: Mm] [stutters] and I often feel, feel lost...

Not only was confusion and a sense of being lost expressed in the content of what was said, but it was also illustrated in the process of, for example, stuttering, and asking questions about what confused them.

Even at the level of legislation in the area there was a sense of confusion and complexity:

4.4: ...I know they're still haggling over it in England, [4.3: Mhm] but are the changes up here in the new mental health act, that hasn't changed then in terms of..... Cos I know one of the things they're still debating in England is whether they should be able to detain people rather than compulsory treatment of which, BPD is kind of one of the favourites they were looking at [4.3: Yes, that's right] in terms..... Although I don't have any great knowledge of how that applies to [indistinct] up here

4.1: Yeah

4.3: I don't, yeah, it's not the same legislation is it? It's further south, but they haven't, I don't know actually...

This representation of the sub-theme of 'confusion, complexity' was also demonstrated in the group dynamics of FGs 1, 2 and 3. For example, note the group agreement on how difficult working with these clients can be:

1.2: ...ideally you'd want to try and teach somebody how to have good relationships but that is such a difficult thing [1.5: Mhm] to do if somebody never has [1.4: Mmm] had that

1.1/1.3/1.4/1.5: [nod]

1.1: Mmm

3.3.2.3 Pressure to do Something

A sense of urgency, or a responsibility to do something to help their clients with BPD, was expressed by several participants:

3.2: ...I just felt so much pressure was on me to make this person better because she was so young [3.3: Mhm] and she was, you know, almost really becoming institutionalised and um I just, I don't know I just felt from the start that there was so much pressure on me to get her better...

One participant conveyed a sense of pressure to do something about other professionals being angry and unhelpful with her client:

4.3: ...I was quite, shocked isn't quite the right word but coming out of it thinking really, you know, I ought to be trying to do something to, if these people are (all to be) involved with this guy...

While the sub-theme of 'pressure to do something' was expressed across all groups, it was particularly evident amongst trainees, through group agreement in FG 1:

1.5: Yeah cos you don't want someone to hurt themselves, [1.2: Mhm] it's just kind of human nature [1.4: Mhm] that you want someone to be okay, and especially if [stutters] you know you are their psychologist [1.1/1.2/1.3/1.4: Mhm] and trying to be helping them and they're hurtin' themselves [1.4: Mmm] it's.....

3.3.2.4 Frustration

Several participants across all groups commented on being frustrated with clients with BPD. However, this was not spoken about in any level of rich detail, with the exception of the following two examples:

4.4: I think it can be really hard [4.2: Mhm] I think, cos sometimes you just want to [laughs] give them a shake and [laughs] [4.2/4.3: laugh] you know, and say get a grip and [4.3: Mm] just consider the bigger picture sort of thing, yeah it's hard I think, you know, I can certainly think of occasions where I've sort of sat on my hands and just not said anything, rather than risk sort of saying something, saying the wrong thing and kind of upset somebody...

1.4: ...if I bring sort of exercises or certain things to work through then I'll maybe go through it in the session, but then you know she'll maybe find that it doesn't work, or she finds that it sounds really difficult to do and you have to adapt it, or you have to just scrap it and do something else, em and quite often you know she'll say 'Well I've tried that and it doesn't work what else is there? Is there nothing else you can do to help?' Em you know 'I can't do this, I can't do that, so what else is there, there's nothing for me', you know those sorts of remarks, em.....

The list-like narrative of the apparently uncooperative responses that 1.4 was met with helps to convey a sense of the growing frustration she experienced.

The group dynamics in FG 2 also emphasised this theme, through the knowing laughter around 2.2 admitting to feeling annoyed at a client with BPD:

- I: And how did that make you feel when she was doing all that?
2.2: Yeah, quite annoyed [laughs] [2.1/2.3/2.4: laugh]

On the other hand, this laughter may also have been a reflection of an awareness of this comment being negative, a sub-theme explored in section 3.3.7.1.

3.3.2.5 Anxiety

The sub-theme ‘anxiety’ was represented in the narratives of many participants, across all FGs. For some participants, this was in relation to being faced with the prospect of working with these clients without ‘feeling equipped’:

- 2.3: I guess I would feel..... Say by chance I was to see somebody, I don't think I'd feel equipped enough to make that kind of diagnosis, or even [2.1: Mhm] pick up on things, you know, I think, I guess with supervision..... [stutters] I just don't feel I've got enough knowledge and background to a lot of things, which is kind of a worry [2.1/2.2: laugh] [laughs] when you're seeing people...

Even those at later stages in their careers voiced similar concerns about the services:

- 4.3: ...in a way, services aren't geared up to dealing with them and I worry, that's a bit of a worry I think about them...

For several participants, their anxiety conveyed a sense of danger:

3.1: I remember distinctly having conversations with [removed] in supervision, and the secretary, about where I should see him, what room I should see him in, and he had no history of any violence, there was no indication, yet I felt so unsafe with him [3.2: Mmm] [3.3: nods] and yet there was no, [3.2: Yeah] you know like, I mean I remember we were, for his very final appointment putting me in the room so I was right through the wall in [removed] so that, so that you know like, I would be safe and yet I never knew what I was unsafe from, [3.3: Mm] but there was this feeling and it was quite a strong feeling but I don't know, [3.2: Mm] you know it just doesn't make sense, why would I feel like that, [3.2: Mmm] but it was quite [3.2: Mhm] nerve wracking...

Group dynamics across all groups, such as the above group agreement at 3.1's experience, furthered the evidence for this sub-theme.

3.3.2.6 Low Self-Efficacy

The concept of self-efficacy was originally defined as an individual's belief that he or she is capable of overcoming difficulties successfully (Bandura, 1977). The sub-theme 'low self-efficacy', whereby participants' belief in their ability to deal with clients with BPD successfully was low, emerged in the narratives of all participants. While this may be regarded as a cognitive phenomenon, as it appeared to be expressed in terms of related feelings, it was included under 'undesirable feelings in the psychologist'. Some participants spoke about a lack of control, or helplessness:

2.4: ...there was still this stuckness there, that you couldn't quite move on, [2.2: Mhm] even though yes, uh huh, that seems perfectly reasonable, it was just, you know, moving it on and the next day meeting [2.2: Yeah] and it would be something completely different, so it was..... You almost felt fire-fighting [2.2: Mhm] and you just felt completely powerless to do anything [2.2: Mhm] and this person was clearly saying 'help me', [2.2: Mmm] but not, you know, not feeling able to help that person...

The use of the 'fire-fighting' metaphor gives a sense of the psychologist using reactive responses with the client, which they do not feel can lead to any real progress.

Others, mainly trainees, conveyed a lack of confidence in the area of BPD, which was often present in the process of undervaluing their own knowledge in the group:

1.3: ...I don't know that much about it but I think they fluctuate? [1.1: Yeah] I don't know, you will know more about it than I do [laughs]

Some participants spoke explicitly about how working with clients with BPD can lead to feelings of failure:

4.3: I was with someone recently and I knew this person was borderline, I knew the history and I'd been set up to be the person to take this person, this woman on, a new woman it was, and I blew it, [laughs] [4.1/4.2/4.4: laugh]...

I: And how did that make you feel?

4.3: Well I'd completely failed...

3.2: ...two people that have made me worried most are the people that have attempted suicide [3.1: Ah, that's different] and it's, and that is just, I think it's to do with, well maybe you could say it's being projected into me, but there's also it's a sense of something that would be that, you know, you'd feel like a complete failure [3.1: Yeah, yeah] because you've not been able to do anything or you haven't been able to save them...

All groups showed signs of whole group agreement on this sub-theme. For example, note the knowing laughter following 4.3 telling the group that she 'blew it'.

3.3.2.7 Oscillating Between Extremes

A sub-theme which was represented in several narratives, but notably only those in FGs 3 and 4, was that of the psychologist also oscillating between extremes when working with clients with BPD:

3.2: it was like one minute I'd go 'Wow yeah he's making progress, [3.1: yes] yeah!' and the next 'Oh my goodness, I'm incompetent [3.1: Yeah/laughs] and he's letting me know that', [3.1/3.2: laugh] [3.1: Yeah] it was yeah, [stutters] it is the kind of, the extremes of emotions you feel

4.3: It's a roller-coaster isn't it? [4.1: Mhm] [4.4: Mm] [4.3: Mhm] Yeah, and because it's intense, yes you get trapped in that [4.1/4.2/4.4: laugh/nod] [laughs]

Agreement through group dynamics was shown in both FGs 3 and 4, thus strengthening the evidence for this sub-theme. For instance, note the agreement and knowing laughter around 4.3's analogy of being on a roller-coaster ride.

3.3.2.8 Reflections on 'Undesirable Feelings in the Psychologist'

In general, the reported 'undesirable feelings in the psychologist' in relation to working with clients with BPD, are similar to the findings of studies with other professions (e.g. Nehls, 2000) as well as CPs (Brody & Farber, 1996; Servais & Saunders, 2007). For example, the sub-theme 'confusion, complexity' is consistent with the confusion reported by CMs, in regarding for example, how much concern they should express over clients with BPD self-harming (Nehls, 2000). However, this specific sub-theme has not been indicated in previous research with CPs, thus, adding importance to the current finding. The sub-theme 'oscillating between extremes' is similar to Nehls' (2000) finding that CMs tended to oscillate between feeling that they were both over and under concerned about these clients. However, the previous quantitative research in this area with CPs (Brody & Farber, 1996; Servais & Saunders, 2007) did not investigate this phenomenon.

CPs in the present study feeling frustrated with clients with BPD, is a finding which is consistent with previous research with psychiatrists (Lewis & Appleby, 1988) and CPs (Brody & Farber, 1996). Similarly, the sub-theme of 'anxiety', specifically in relation to a sense of danger, is consistent with findings with nursing staff (Markham, 2003), and CPs (Servais & Saunders, 2007). As Markham (2003) highlights however, research indicates that clients with BPD are more likely to self-harm than harm others (Trestman, 1997). The present finding adds more depth to the previous findings, by illustrating feelings of anxiety not only in relation to a sense of danger, but also regarding not feeling equipped to work with the client group.

Indeed, the feelings related to 'low self-efficacy', have also been reported in the general literature on psychotherapy. For example, Theriault & Gazzola (2005) indicate that feelings of incompetence are an ongoing part of the inner experience of clinical psychologists. More specifically, in the BPD literature, Brody & Farber (1996), for example, found that CPs felt less helpful in their work with clients with BPD compared to those with depression or schizophrenia. However, the current findings are noteworthy, as they illustrate the feelings reported in Brody & Farber's (1996) study in more depth. For example, it appears that one of the factors related to feeling less helpful may be a lack of confidence in working with clients BPD, as reported in the current study.

Aspects of 'undesirable feelings in the psychologist' were found in the present study which have not emerged from previous research in the area. For example, while the sub-theme 'pressure to do something' is consistent with Main's (1957) suggestion that clients with BPD want others to be responsible for their emotional pain, the current study is the first to report this feeling of responsibility from the accounts of staff themselves. Additionally, feeling 'overwhelmed' in relation to working with clients with BPD has also not been specifically mentioned in previous research with staff.

Interestingly, several aspects of the sub-themes within 'undesirable feelings in the psychologist' appear to mirror the 'negative perceptions of the client'. Indeed, participants had commented that they wondered if the client's negative feelings were being projected onto them. According to Freud (1910/1957), projection is a defense mechanism whereby one projects one's own undesirable traits onto others, to defend oneself from threat. It is possible that the psychologists had been experiencing concordant trial identifications with the clients (see section 1.4.1). However, the reverse could also be true, in that the undesirable feelings in the psychologist could have been projected onto the client, leading to negative perceptions of the client (a possibility also raised by 1.2 in section 3.3.7.3). For example, when psychologists were experiencing feelings related to low self-efficacy, they may have been projecting this onto the client, and in effect viewing the client as having a limited

ability to change. It is possible that either of such processes, or perhaps both, were in place for the participants in the present study (for further discussion, see section 4.5.2).

As with the first superordinate theme, all participants expressed undesirable feelings in relation to clients with BPD, regardless of the stage in their career, suggesting that factors related to being at a later career stage have not reduced negative feelings regarding clients with BPD for this group of CPs. This is consistent with the findings from Markham's (2003) study with nursing staff, and Brody & Farber's (1996) study with CPs in the US.

Interestingly however, the sub-theme of 'oscillating between extremes' was strongly represented in qualified psychologists' transcripts and yet not identified at all in those of trainees. This would suggest that the phenomenon of the psychologist 'oscillating between extremes' arises with experience in working with clients with BPD. Therefore, perhaps it is projected onto the psychologist by client. However, some trainees also had experience in working with this client group, suggesting that some other factor, such as the therapists at later stages in their careers perhaps being more aware of their own feelings, may have accounted for the emergence of this theme within those groups only. This possibility is consistent with Brody & Farber's (1996) study, which found that more experienced CPs are more comfortable with their emotional responses to clients.

3.3.3 Positive Perceptions of the Client

'Positive perceptions of the client' emerged from the narratives of all but three participants (1.2, 2.2, and 4.4). This superordinate theme was represented in rich detail by some participants. However, overall it was not spoken about as in depth as the previous superordinate themes.

3.3.3.1 Possibility of Change

While the sub-theme of ‘possibility of change’, whereby participants conveyed a sense of hope that clients with BPD can change, emerged in several trainees’ narratives, this was not represented in great depth. On the other hand, most of the participants in FGs 3 and 4 spoke about the possibility of change in more detail, often drawing on examples of their own cases. One participant provided an example of how her client with BPD changed due to factors out-with therapy:

3.3: ...at the moment she’s going through quite a good, a good patch because um she, her and her boyfriend, em, take drugs, and he’s moved out now and em she’s on a methadone programme and her life has become full of routine again and that seems to have had an effect on everything, including her intrusive thoughts, so she’s going through quite a good patch now...

It is interesting to note, however, that 3.3 uses the phrases ‘at the moment’ and ‘good patch’, which imply that she does not expect her client’s recent gains to last. This also reflects the earlier sub-theme ‘ability to change limited’ (see section 3.3.1.4).

Others shared experiences of these clients changing as a result of therapy:

3.1: ...so we actually, you know, had a sociable ending that happened amicably, where there wasn’t a big fall out, which is what I expected he was gonna have to do [3.2: Mm] to be able to deal with leaving but we ended with shaking hands and him saying ‘Thank you very much [3.2: Oh/smiles] you’ve been really helpful’...

Group agreement also strengthened the evidence for this sub-theme in FG 3:

3.1: ...hopefully I’d set him an example of that you can have positive helpful relationships that don’t end, you know, with a big argument in tears and walking out slamming the door [3.2/3.3: Mhm]...

3.3.3.2 Likeable

A few of the participants in FGs 3 and 4 portrayed clients with BPD as being likeable individuals:

4.1: ...well I really liked her despite..... [4.2: Mhm] And then the other person, I definitely, well I think back on her fondly...it actually ended because I was going on maternity leave...and she got me this lovely picture of a, of em, a mother elephant and a baby elephant [4.3: Yeah, yeah/nods] so and, and you know, and there were lots of good moments as well [4.3: Mhm] [4.2: nods]...cos often people are very likeable [4.2: Yeah] and have got all the positive qualities...

4.2: ...what they're looking for is not to be abandoned [4.1: Mhm] and to be looked after and to be nurtured and so, I guess you're put in that role as well, you find yourself being concerned about them...they're often very likeable, [4.1: Mhm] you do have this positive, see the positive qualities in them as well

3.3.3.3 Reflections on 'Positive Perceptions of the Client'

There is a paucity of research on positive perceptions of clients with BPD. When positive perceptions have been mentioned, this has been in the context of improved staff attitudes following training programmes (e.g. Krawitz, 2004), rather than investigating perceptions as they are. As such, the emergence of the sub-theme 'possibility of change' is noteworthy, particularly given that there is indeed evidence for promising psychological interventions for this client group (Bateman & Fonagy, 2000). Viewing clients with BPD as having the possibility of changing contrasts with the pejorative connotations of the BPD label being seen as unchangeable.

The finding that some CPs view clients with BPD as likeable is contrary to the findings of Brody & Farber (1996) and Servais & Saunders (2007). For example, Brody & Farber (1996) suggest that CPs view clients with BPD as being the least likeable compared with clients with depression or schizophrenia. Perhaps the results of the present study appear to differ from the above due to such studies comparing participants' views over different client groups. However, the present findings also differ from those of Nehls (2000), who used a similar approach to the present study with CMs, and found that they expressed mere indifference towards their clients with BPD. The finding that the CPs in the present study did express some positive views

of clients with BPD, despite such previous findings with CMs is reassuring, particularly given that CPs may become clinical leaders in the area.

Interestingly, positive perceptions of clients with BPD emerged in depth only in the narratives of fully qualified staff, with the sub-theme of ‘likeable’ not emerging at all in trainee narratives. This is in contrast to the findings of Markham (2003) and Brody & Farber (1996), who reported no improvements in perceptions of these clients in staff at later stages in their careers.

3.3.4 Desirable Feelings in the Psychologist

‘Desirable feelings in the psychologist’ emerged from the narratives of all but two participants (1.1 and 4.4). This superordinate theme was represented in moderate depth by some participants. However, like ‘positive perceptions of the client’, overall, it was not spoken about as in-depth as the first two superordinate themes.

3.3.4.1 Empathy

A sense of an emotional response to the emotional distress of clients with BPD was evident in the narratives of participants in all groups. For some, this was in relation to their own experiences with clients:

3.1: I think it was quite hard for him

3.3: Poor girl

4.2: ...I think you can't help but have a human reaction to their distress, [4.1: Mhm, mhm] even though you've kind of got your professional head on...

For others, namely trainees, empathy appeared to arise from the process of discussing the client group within the FGs:

1.3: ...there's quite a lot of negative things that just talking about this has brought up [1.5: nods] em I think it'd be..... One thing that would be really important is to try and just stay open to that person as a human being [1.2/1.4: Mhm] and try not to just write them off as somebody who's [1.1: Mhm] em..... Cos even if they are [1.5: Mhm] behaving in ways that are difficult then, I don't know, it's not necessarily intentional [1.2/1.5: Mhm] and there's got to be a lot of issues there and a lot of hurt for that, you know, to develop that in that way in the first place I think
1.1/1.2/1.4/1.5: [nod]

The evidence for this sub-theme was strengthened by group agreement in FGs 1 and 3, such as the group nodding in the above example.

3.3.4.2 Interest

A sense of feeling interested in clients with BPD was conveyed by several participants, throughout all FGs. Particularly for trainees, this was an interest in the client group in general:

2.1: ...I think it would be kind of exciting and really interesting...yeah I think it would be really interesting and you'd probably find yourself getting hooked in...

The use of the phrase 'hooked in' emphasises a sense of a somewhat compelling interest that clients with BPD can rouse in the psychologist.

For those in FGs 3 and 4, the interest was often conveyed with reference to their own particular clients:

3.1: ...she's the only person I've ever seen who em, could, I can't remember the official word here, could split herself and become a four-year-old child, in session, [3.2: Oh right] fascinating, [3.2: Wow]...

-
- 4.1: You do wonder how they're doing
4.3: Yes, that's right! [laughs]

The evidence for the sub-theme of 'interest' was also demonstrated in the group dynamics of FGs 1, 2 and 3. For example, note the group interest 3.1's client in the above example.

3.3.4.3 Reward

Some of the participants in FGs 3 and 4 portrayed working with clients with BPD as gratifying. The following example of 3.1 continuing her narrative about her client having a successful ending to therapy (see section 3.3.3.1), illustrates a sense of satisfaction:

- 3.1: ...I was quite pleased about that, [3.2: Mm] which I think actually the very ending and the fact that he'd coped with that helped my fears about stalking because I thought actually he impressed me that he was able to do that...

Some participants conveyed a sense of being made to feel 'special' by such clients:

- 4.2: I think all the, kind of, getting pulled in emotionally can also get to feel that you're the special one, as well, you know, the one that's gonna fix everything, that is the only person that's ever listened to them before, em, the only person that's taken them seriously [laughs]

Although participants implied that this could be potentially positively reinforcing, they described attributing this process to the client's BPD presentation, and using this reasoning to also resist the sense of flattery:

- I: And what's that like, to be –
4.2: I think if you, I think if you don't know they're borderline you maybe kind of, [pauses] I guess it's easy to be quite flattered by it, um, and I think if you've got that kind of objective head on, then you can say well this is part of their, [4.1: Uh huh] of their presentation, like I'm

gonna be like this but next week I could be the, you know, the worst therapist they've ever had, so.....

3.3.4.4 Reflections on 'Desirable Feelings in the Psychologist'

Again, there has been little mention of 'desirable feelings in the psychologist' in relation to clients with BPD in the previous literature. Therefore, the emergence of this superordinate theme in the present study is noteworthy, as it challenges the notion that such clients are only associated with negative feelings in staff.

The finding that CPs report being interested in, and empathising with these clients, as well as finding such work rewarding, appears somewhat different from previous findings such as those of Brody & Farber (1996), which indicated that CPs rated their positive feelings as being lowest for clients with BPD compared to clients with depression or schizophrenia. Even on the exception of 'gratification', participants rated clients with BPD as lower than clients with depression. However, clients with BPD not being rated the lowest on 'gratification' supports the emergence of the sub-theme 'reward' in the present study. Also, the participants in Brody & Farber's (1996) study appeared no less interested in working with clients with BPD than those with depression or schizophrenia, which supports the sub-theme 'interest' in the present study. Indeed, perhaps the results of the present study only appear to differ from those of Brody & Farber (1996) due to the latter comparing participants views over different client groups. Yet, the present findings also differ from those of Nehls (2000), who in her similar approach to the present study, did not report any desirable feelings in CMs towards their clients with BPD. Again, the finding that CPs in the present study did convey desirable feelings in relation to clients with BPD, despite such previous findings with CMs, is encouraging.

The sub-theme 'reward', only emerging in the narratives of fully qualified staff again challenges the findings of Markham (2003) and Brody & Farber (1996), which indicated no improvements in the feelings regarding these clients, in staff at later stages in their careers.

3.3.5 Trying to Make Sense of the Chaos

A superordinate theme which emerged within all groups and all participants, and was represented in rich detail throughout, was that of ‘trying to make sense of the chaos’. The researcher felt that this term, which was used by 1.1 (see section 3.3.5.2) most aptly encapsulated the cluster of sub-themes which follow, in that these are a range of processes that the CPs in the present study are aware of engaging in, in order to attempt to bring some clarity or understanding to the presenting problems of people with BPD.

3.3.5.1 Searching for Explanations

All participants conveyed a sense of searching for explanations for BPD. Many formulated, or pondered, over possible factors that might explain the presenting difficulties in these clients. For some this was in relation to clients in general:

1.3: ...if somebody's got boundary issues then you'd imagine that then where they've grown up there's probably boundary issues as well and that's maybe why they haven't learned that

1.5: Yeah, mhm

1.4: So it's a bit of a pattern throughout families?

1.3: Em I'd imagine so, I mean I don't think it comes out of nowhere

1.4: Yeah

For others, this was in relation to particular cases:

3.2: ...she self-harms a lot as well, [3.3: Mhm] um but I think she directs it at herself because she feels she can't actually let it out at the person she's angry with...

Some participants specifically spoke about how formulation can be used as a way of helping to explain BPD:

2.4: I suppose that's where things like, I suppose from our point of view, that a formulation of all the different factors [2.2: Uh huh] [2.1: nods] that's where that kind of thing with these really complex cases, where that could be very, very useful, [2.2/2.3: Mhm] [2.3: nods]...

A few participants spoke about how being aware of one's own feelings can also help in the search for explanations:

1.1: ...I just kind of felt more [pause] angry or confused or I didn't know what to make of it or something like that and it wasn't to do... it wasn't so much to do with my own issues and then when you start looking at what [stutters] how they kind of related to people in the past, I think that's maybe, maybe more a, you know, better explanation; this is how they conduct their relationships, that there's kind of patterns and cycles and eh that you can't... the [stutters] kind of stories they tell and the problems they report, when you look at how they kind of related to you then you kind of go mm, if you were the same with other people then there's no wonder that there's this and that.....

In the above excerpt the somewhat distorted speech, including stuttering, possibly reflects the confusion felt by 1.1 when working with her client before she made sense of her own feelings. The insight gained into the client's difficulties following such an exploration of 1.1's own feelings is reflected in the clarity of the flow in her concluding sentence.

The evidence for the sub-theme of 'searching for explanations' was strengthened by the group dynamics in FGs 1, 2 and 3. For example, note the whole group agreement on 2.4's above view on formulation.

3.3.5.2 Providing Structure, Boundaries

Several participants across all groups spoke about the usefulness of providing clients with BPD with a sense of structure, or boundaries, within the therapeutic relationship:

1.4: ...the more I've seen her, and the more I sort of stick to, you know, boundaries and she's aware of what the boundaries are, then the more comfortable she's actually becoming [1.2/1.5: nod], you know, em like for instance, she's asked em for forty minute appointments because she finds fifty minutes too tiring, and so we agree on forty minutes and then em the next time she came, em you know, I said well forty minutes today and she said 'Oh no, no, I must have fifty minutes today because I'm just terrible today and I need the extra time' but because we'd already sort of set the forty minutes I thought to myself well no I have to stick to this...and so just wee things like that have made her...more comfortable in the sessions...

1.1: ...also getting consistency and in a way what we were saying earlier, you have to work through some stuff in sessions...and um trying to work through some of those relationship cycles people go through so you kind of try and look at them and take them apart, structure..... I suppose structure, one of the ones [makes eye contact with 1.4] you said earlier, [1.4: Mhm/nods] trying to make sense of the chaos

Some spoke about how this could be beneficial for the therapist as well as the client:

3.3: ...if I can just sort of try and give them a good experience of a relationship so maybe, you know, who knows in the future, they're in a better position to seek input again, then that's, that's quite important, and that might actually make me feel a bit, a bit less under pressure...

3.3.5.3 Normalisation

Again, in contrast to the 'different, odd' sub-theme, many participants, across all groups, also drew on similarities between clients with BPD and other clients, as well as the general population:

3.1: ...I've seen quite a lot of people who've cut, you know, whether it's been as a trainee or as an assistant, cos I worked with teenagers, so I guess there was quite a lot of self-harm and that type of thing and so I imagine, I just imagine that being kind of an obvious, an obvious outlet for emotions

2.4: ...you have this continuum...you get similar types of personalities whoever you meet...

Some attempted to explain the function of behaviours in BPD by implying that anyone would behave in such a way in similar circumstances:

1.1: ...I mean what kind of control over things I know that this guy had, he lived in a very restrictive environment, he was on a section, you know kind of, what do you do, you try to get control over certain things with, you know, manipulating what else is going on around you...

Note how in the above excerpt, the use of second person as opposed to third person, serves to undermine any sense of difference from the general population.

When emphasising that many people in the general population could easily meet criteria for BPD, one participant drew overt comparisons with herself:

3.2: ...I sometimes think of myself as like having done something really silly or, or been really split by things and like when we had a chat yesterday about me kind of feeling like I'm sometimes, like betraying one person by saying this [3.1: Uh huh] and betraying another by saying that [stutters] and feeling like I have all these horrible thoughts in my head and I'm like, maybe I've got personality disorder [3.1: laughs] and nobody's told me yet, [3.1/3.3: laugh] you know cos, d'you know what I mean, [3.3: Mm/nods] [3.1: Yeah, yeah/nods]

The group agreement in the above excerpt strengthens the evidence for the sub-theme of 'normalisation' further.

3.3.5.4 Working on Engagement

Most participants in FGs 3 and 4, as well as 2.4, emphasised that in order to engage clients with BPD, psychologists need to work on building up a trusting relationship:

2.4: ...you're building up a, you know, a safer relationship as possible [2.2: Yeah, yeah] [2.3: Mhm] before, instead of going right in at the core issues stuff

3.3: ...another reason why um, how trust can be important is when patients miss sessions and um continuing to see them, I think is [3.2: Yeah] [3.1: Mm] very important with this client group

4.2: I guess you've really got to be on their side at first, to get them knowing that you're going along side them, um.....

Within FG 3 the evidence for this sub-theme was strengthened further by the group agreement with 3.3's view that clients with BPD should still be seen after missing sessions.

3.3.5.5 Working on Different Levels

A sense of there being different levels that one could focus on in working with clients with BPD was conveyed in the narratives of several participants, across all groups. Particularly for the trainees, the preferred focus was on working around the PD, or focusing on the symptoms 'on the surface':

2.1: ...would you actually start to see a shift if you were treating some of the [stutters] [2.4: Mm] smaller things bit by bit, looking at one problem at a time and kind of going through those would then start seeing a shift in the whole thing [2.2: Mhm] I wonder..... I don't know if there's any evidence for that

2.4: Mm, you mean like working on things like, if somebody was, was feeling low and depressed a basic kind of activity plan?

2.2: Mhm

While fully qualified staff also described working at this level, they tended to convey a sense of difficulty in it, and highlighted the value of working at a deeper level:

3.2: ...where you just get stuck on the, on the maybe slightly hi- you know, more behavioural [3.3: Yes] cognitive level and you're just kind of like mm, or even emotional level that you, if you don't go there then you, we're gonna stay stuck ...

3.1: ...although we never explicitly talked about the fact that the relationship stuff was going on...I mean, I talked about cycles in his life, we talked about relationships but, you know, it could, [stutters] if I was say like focusing on, okay he has a personality disorder, we're gonna share this with him, we're gonna help him work through how, [stutters] you know, in some

ways I think that could actually potentially be quite exciting [pauses] for him, [3.2: nods] you know, to be able to be free, to be able to move on, to be able to understand it...

Later in the above excerpt from FG 2, a trainee suggested balancing the focus:

2.1: I suppose there's potential to always just be skirting around the outside of the issue if you do, [2.4: Yeah] if you don't try [2.2: Mhm] and get in so it's about finding that balance [2.4: Mhm] between doing little bits that you can do change and actually maybe using that as a pathway rather than keep going round in a circle round it

Note how the use of the word 'pathway' also serves to create a sense of hope for change, linking into the sub-theme 'possibility of change' (see section 3.3.3.1).

One participant also suggested 'timing' may be an important factor in deciding what level to work on:

3.1: ...sometimes, you know, you might get someone and at that stage in their life, for whatever reason, they're ready to deal with, with things from the past [3.3: Mm] and other times...I always think of it like a patch up job, [laughs] I mean a patch up job so you can just continue to function for at that time in the future [3.2: Yeah] [3.3: Mhm] where maybe life is a bit more stable and you're ready to totally re-evaluate the fact that [3.2: Mhm] the way you've been living your life [3.3: Mhm] is just been kind of going round in circles...

The evidence for the sub-theme 'working on different levels' was strengthened by group agreement in FG 3, such as in the above example of 3.1 discussing the importance of timing.

3.3.5.6 Reflections on 'Trying to Make Sense of the Chaos'

The notion of a range of processes that staff engage in, to attempt to bring some clarity or understanding to the presenting problems of people with BPD, has not been mentioned in the previously reported studies of staff perspectives on these clients. Quantitative studies such as that of Servais & Saunders (2007), did not aim to investigate such factors, and as such, did not enable the presence of such a notion to be explored within the participants in those studies. However, the finding that CPs

rated clients with BPD as less understandable than those with depression, yet more understandable than those with schizophrenia, and interestingly, similarly understandable to 'a member of the public' (Servais & Saunders, 2007), supports the notion that CPs apply some level of understanding to the presenting problems of BPD.

While the sub-theme 'providing structure, boundaries', was similar to the reported theme 'monitoring boundaries' in CMs (Nehls, 2000), it appeared that in CMs, this process was used in order to deal with staffs' own anxieties. Yet, in the present study, it appeared that while such processes were acknowledged by the participants as being beneficial to themselves, they were largely illustrated in terms of benefits to the clients. A further difference in this superordinate theme and those in Nehls' (2000) study, is in relation to the sub-theme 'normalisation'. Participants in the present study appeared to use this process to try to understand behavioural presentations of BPD, such as self-harm. On the other hand, the CMs in Nehls' (2000) study reportedly closely monitored and struggled with their expression of concern over self-harm. In fact, the present study also covered a similar sub-theme of 'pressure to do something' (see section 3.3.2.3). However, it seems that by also employing strategies under the 'trying to make sense of the chaos' superordinate theme, CPs in the present study attempt to understand such behaviours. Given that these findings with CPs and CMs are from small numbers of participants, and through qualitative research alone, it is not possible to say if such reported differences in the findings are a result of any differences between perceptions or experiences in different professions. However, if CPs are a profession who attempt to understand the difficulties encountered by people with BPD, this is reassuring, given the central role of formulation in informing effective interventions for this client group (Alwin *et al.*, 2006).

Several aspects of this superordinate theme are consistent with previous research in the area of BPD in general, as well as literature on the role of CPs in this area. For example, the sub-theme of 'normalisation' is consistent with Costa & McCrae's (1992), five-factor model of personality (Widiger & Frances, 1994) and the BPS

view that PDs are exaggerations of 'normal' personality traits (Alwin *et al.*, 2006). Thus, the emergence of the superordinate theme 'trying to make sense of the chaos' is noteworthy, as although the importance of the related issues such as formulation, the therapeutic relationship, the notion of a continuum, and the possibilities of working with different approaches with clients with BPD, have been documented previously, and have been highlighted recently by the BPS (Alwin *et al.*, 2006), the present finding provides evidence that CPs have indeed been utilising such strategies, and finding them helpful with this client group.

The sub-theme of 'working on engagement' being mainly found in the narratives of fully qualified staff may be due to staff learning that this is important through experience with working with the client group. Differences between trainees' and the fully qualified staff's narratives within the sub-theme of 'working on different levels' could also possibly be due to staff learning through experience that using unmodified CBT, for instance, to deal with a single 'symptoms' such as low mood, has not been as effective as anticipated with these clients, and that other approaches, such as psychodynamic psychotherapy, or specific cognitive therapy for PDs, with its additional focus on factors such as the therapeutic relationship (Davidson, 2000), may be more appropriate. It is also possible that the differences between trainees and fully qualified staff in the emergence of these sub-themes are due other factors (see section 4.2.3).

3.3.6 Working in Contrast to the System

A sense of CPs working in contrast to other services within the NHS and the medical model itself, with regards to clients with BPD, emerged in the narratives of all participants. This superordinate theme was conveyed in moderate depth.

3.3.6.1 Problems with Diagnosis

An emphasis on the problems with the BPD diagnosis was expressed by all participants. This sub-theme was expressed in rich detail by many participants. For some, the problems were in relation to the validity of the diagnosis:

2.1: It almost seems like a lot of the other personality disorders, like you've got narcissistic, and it's, you know, obviously about being really into yourself and things like that, and then psychopathic is about your lack of feelings and empathy and things like that, and they seem to have this kind of definite thing and borderline, well to me it seems to be like everything that's left over [2.4: Mm/nods] clumped in kind of..... [laughs]

Yet, some participants highlighted the potential benefits of the BPD diagnosis:

4.3: One person I had...said 'That is me I know I have this, I'm sure I have'...'It's a relief [4.1: Mhm] to find somewhere where I fit, [4.2: Yeah] somewhere where.....', em and...really delighted [4.1: Mhm] with the idea that 'There's somewhere where I can hang this on [4.4: Mm] there are interest groups there, [4.2: Mhm] [4.1: Yeah] I can read up about it'...

However, there was a sense of the diagnosis not always being given with such benefits in mind:

1.2: ...maybe in some ways [stutters] it's a giving up [1.1: Mm] if it's after, been so many years of different professionals working with them it's almost maybe a professional's way of saying go away [1.3: laughs] because I don't know what to do with you, it's part of your personality so, I'm not going to be able to help you...

4.1: ...I think if it's gonna be diagnosed it's got to be really done properly, with the person's well-being in mind [4.4: Mhm] if it's gonna be beneficial to them in the longer run...

Some also emphasised the negative consequences of the diagnosis:

4.2: ...if people are diagnosed then sometimes they can be denied services, [4.1: Mhm] [4.3/4.4: nod] if they've got personality disorders then, you know, we don't treat them, [makes

eye contact with 4.4] as you were saying they do with the forensic team, [4.3: Yeah, that's right] whereas clearly they might have forensic issues like your patient with the guns [laughs]

Participants' laughter in above excerpts emphasises how absurd they perceive the diagnosis and its associated implications to be. Further evidence for this sub-theme is that many participants reported having worked with clients who they think met criteria for BPD, but were not diagnosed (see section 3.1). This may reflect the diagnosing clinician's similar sensitivity to this issue, and desire not to label someone with a diagnosis that may be hurtful. Thus, confusion over the diagnosis, and the experience of working with people who may have BPD but have not been given the diagnosis, adds weight to the sub-theme 'problems with diagnosis'. Furthermore, group agreement within FGs 1, 2, and 4, such as the above agreement with 4.2, also adds strength to the evidence for this sub-theme.

3.3.6.2 Impact of Psychology Limited

Most participants, across all groups, identified several limitations on the impact of psychology on intervention for BPD. Many of such limitations were in relation to financial and time constraints of the NHS:

3.3: ...it's like we're not set up for that in sixteen sessions

1.5: ...I've not heard of any clinics em for people with person, eh, personality disorders, cos it would take whole lot of money

Some conveyed a sense of being limited by the agendas, or sometimes unhelpfulness, of other professionals:

1.1: But I mean the whole health system really is based on [pause] diagnosis, and having, having that label, and we're not necessarily working in that field, you may not end up diagnosing because you're doing formulation, but a lot of where you look, you know people only just want two or three sentences of summary about whether this person's got personality disorder

4.3: ...very difficult to deal with the case, because if you wanted to do anything, there were these really hostile people who weren't gonna do anything they didn't have to do for this patient...

Evidence for this sub-theme is strengthened by group agreement in FGs 1, 2 and 4. For example, note the knowing laughter from the group in the following excerpt, as 2.4, when discussing the role of psychology in sharing formulations with other professionals in teams, brings the discussion back to her perception of the reality of NHS with the phrase 'in theory':

2.4: ...it could be used in the context of, you know, this is how we understand this person and as a service and as, you know, a particular profession, this is where we come in particular areas, rather than a kind of one-to-one therapeutic kind of approach but [2.2: Mhm] [2.3: Sounds good] [2.1: Mhm] yeah in theory [laughs]
2.1/2.2/2.3: [laugh]

3.3.6.3 Reflections on 'Working in Contrast to the System'

While Speed (2004) highlights the similar challenges of 'systemic practitioners' in fitting into the complexities of professional systems in the NHS, the particular notion of CPs 'working in contrast to the system' in the area of BPD has not been mentioned in previous research. Although the sub-theme 'problems with diagnosis' is consistent with well documented controversies surrounding BPD (e.g. Nehls, 1998), the current findings are important, as they highlight CPs' perceptions of such controversies in relation to their working practice. Similarly, recent research by Samuel & Widiger (2006), reports that practicing psychologists consider the five-factor model of personality (Costa & McCrae, 1992) to be more clinically useful than the diagnostic system of DSM-IV.

The sub-theme of 'impact of psychology limited' has also not been previously reported in studies of CPs' perspectives on BPD. However, CPs in the present study perceiving financial and time constraints on the impact of psychology, is consistent with the lack of evidence for the cost effectiveness of interventions for BPD. For

example, a recent study indicated no significant cost-effective advantages for CBT for BPD (Palmer *et al.*, 2006). While differences in how practicing psychologists and psychiatrists view BPD have been reported in previous research (Ochoa & Morey, 1990), the current finding that CPs view other staff as sometimes being unhelpful in the area of BPD, has not been previously reported. The emergence of this sub-theme is concerning, given that CPs may become clinical leaders in the area of PD.

The superordinate theme of ‘working in contrast to the system’ emerging in the narratives of participants across all groups, in both staff who have worked in CMHTs and primary care, suggests that perhaps this perception exists from the beginning of CPs’ careers. Perhaps factors associated with later stages in careers, such as experience in working with clients with BPD, do not alter this perception.

3.3.7 Awareness of Negativity

A sense of being aware of the negativity surrounding the area of BPD was conveyed in the narratives of all participants. This superordinate theme was represented in moderate depth.

3.3.7.1 Awareness of Negative Perceptions

Most participants, across all groups, conveyed a sense of being aware of negative perceptions of clients with BPD. For many, such as 2.3, who in the excerpt below describes her experience with nursing staff in an inpatient unit, this was in relation to other professionals’ views:

- 2.3: ...some of the staff were saying to me... ‘There’s bad and mad people and people with PD are like bad and people with mental illness are classed as mad’...
- 2.1: ‘Bad’, [shakes head] [2.2: Yeah] ‘bad’ is a very judgemental quote isn’t it?
- 2.2/2.4: [nod]
- 2.3: It is, and the connotations of that, I’m wondering how that impacts on your work –
- 2.1: And ‘mad’ just [laughs]

2.3: 'Mad', it's not very PC is it! [laughs]
2.2: [laughs]

Note how the laughter in the above excerpt serves to emphasise how absurd the participants believe such negative perceptions are.

For many, the awareness conveyed was also in relation to their own, or their own profession's negative perceptions. In the following excerpt, for example, 4.4 uses sarcasm to convey this awareness:

1: Quite a few words have been used to describe how these clients make you feel, is there anything else, I think already, 'overwhelmed' and 'irritated' have been mentioned, are there any other feelings that anyone has had?
4.4: They were all very positive weren't they? [laughs]

This sub-theme emerged in the processes as well in the content of the discussions. For example, note how 1.4 corrects herself for using the term 'manipulating' in relation to her client with BPD:

1.4: ...it was just another way of her sort of manipulating, well not manipulating, but her sort of running, controlling the session...

Most interestingly, there appeared to be a tendency for group silences to occur directly following negative themes emerging in the groups. For example, note how the group becomes silent following 1.4's narrative related to the sub-theme 'controlling manipulative' (see section 3.3.1.2):

1.4: ...she knows, you know, the sorts of things to say to health professionals that mean they won't be able to sort of let her go, em where, you know, with no actual suicidal intent there,
[1.2: Mm] em..... So that can be quite hard
1.5: Yeah it's tricky
[silence]

It is possible that in such instances the participants were censoring negative perceptions, thus signalling their awareness of them being negative, and perhaps, not acceptable to discuss.

Evidence for this sub-theme was also strengthened by the group agreement expressed on the awareness of negative expressions across FGs 1 and 2. For example, note the knowing group laughter in the following excerpt from FG 1, where 1.3 corrects herself for using the term 'awkward':

- 1.3: ...problems with doing their homework and being awkward
1.4: Yeah
1.3: Sorry I don't mean being awkward..... Em not seeing the point of it em..... [laughs]
1.1/1.2/1.3/1.4/1.5: [laugh]

3.3.7.2 Awareness of Avoidance Being Unhelpful

Several participants, across all groups, described either engaging in, or being tempted to engage in, avoidance in the area of BPD. However, this avoidance was conveyed with a sense of awareness of it being unhelpful. For some, this was in relation to certain aspects of therapy with these clients:

- 3.3: ...starting at like the, the easiest [3.1: Yeah] most straightforward point but, you know, you just get lost very easily
3.2: It's so easy to go into the superficial stuff isn't it?...

For a few, it was in relation to avoiding working with clients with BPD:

- 1.2: [laughs] This is putting me off working with people with borderline personality [laughs]
1.1/1.3/1.4/1.5: [laugh]
I: Can you explain a wee bit more about that?
1.1/1.2/1.3/1.4/I: [laugh]
1.2: I wish I hadn't said that now [laughs]
1.1/1.2/1.3/1.4/1.5: [laugh]

1.1: We're all thinking it [laughs]
1.2/1.3/1.4/1.5: [laugh]

Note how the laughter of 1.2, as well as the other group members, including the interviewer, demonstrates the awareness that admitting to feeling 'put off' working with these clients is inappropriate to voice. It should be noted however, that despite this disclosure, the sub-themes 'desire to learn more' and 'value of experience' (see sections 3.3.8.1 and 3.3.8.2 respectively) also emerged within the narratives of the above participants, suggesting that the discussion did not completely 'put them off' working in the area.

The group laughter in the above excerpt is also an example of the group agreement demonstrated in FGs 1 and 4, which strengthens the evidence for this sub-theme.

3.3.7.3 Exploring Why

Several participants, across all groups, also appeared to explore possible reasons for the negative perceptions. One participant portrayed a sense of staff projecting their own feelings onto clients:

1.2: ...you go away having not got through what you wanted to, [1.4: Mhm] and just feel quite sort of powerless and [pause] yeah just like that you should be able to control things a bit better, that's why you're there and [1.4: Mhm] em..... I guess that's why people use words like manipulative because, it's because they feel powerless maybe?

Some attributed negative perceptions to a lack of information sharing among different professions:

4.2: ...they can just turn up to A&E, and kind of, the SHOs on call may not, [4.3: Yeah] will not have the same kind of information [4.3: No, no] available to them, or even the same experience, or the same knowledge regarded to be, you know, [4.1: Uh huh] if there's an agreed plan and way to manage them, it's not likely to be known to everyone [4.3: Yeah] that's going to deal with them, [pauses] I think there can be a frustration for the A&E people that it's kind of self-inflict – or what you hear from them is they don't get any sympathy...

3.3.7.4 Reflections on 'Awareness of Negativity'

This superordinate theme is particularly related to metacognitive processes. Metacognition is defined as a person's own knowledge regarding their cognitive processes (Flavell, 1976). This evaluative process in relation to negative perceptions has not been documented in the previous studies investigating CPs' perceptions of clients with BPD (e.g. Servais & Saunders, 2007). The exploratory nature of the present study, on the other hand, perhaps enabled such a theme to emerge. Similarly, Nehls' (2000) qualitative study also revealed that CMs acknowledged the dangers of their own indifference towards clients with BPD, as well as the dangers of using boundary setting as a form of avoiding connecting with these clients. The present finding in CPs is important, as it suggests that although negative perceptions exist in the CPs interviewed, they are aware of them, and indicate that they think such perceptions, and associated behaviours such as avoidance, are unhelpful.

The emergence of this superordinate theme across all groups perhaps suggests that the awareness of negativity surrounding this client group exists at the start of CPs' careers, and continues throughout. It suggests that while the CPs at later stages in their careers continue to hold negative perceptions of these clients despite gaining more experience in working with them, they also continue to have an awareness of such negativity.

3.3.8 Improving Our Role

A sense of a need to improve the role of clinical psychology in the area of BPD, as well as ways of doing so, was conveyed in the narratives of all participants. This superordinate theme was represented in moderate depth.

3.3.8.1 Desire to Learn More

Most participants, particularly those in FGs 1 and 2, expressed a desire to learn more about BPD:

1.5: ...we should all lobby for more teaching [1.3: Yeah] [1.3/1.4: laugh] on personality disorders

1.2: Yeah

1.1/1.3/1.4: [nod]

3.1: ...since I qualified that's the thing I've kept asking for I'd like...I've really had no training on sexual abuse, I'd really like more help on it...

This was a particularly well represented sub-theme, as it appeared to be not only illustrated in the content of what was said, but also in the process of participants asking other participants about their work with these clients:

1.3: [turns to 1.1] Em the first lady that you were talking about, what made you think that was what was [pauses] what the issue with her was?

Some appeared to develop a desire to learn more as a result of the discussion itself:

2.1: It makes me want to go away and read about it [laughs]

2.2/2.4: Nod

2.3: I was just gonna say that!

The group agreement with the above statement strengthens the evidence for this sub-theme in FG 2.

3.3.8.2 Value of Experience

Most participants, across all groups, indicated that experience in working with clients with BPD is valuable. Some suggested that it would be particularly helpful for trainees:

1.2: ...if you're not on flexible specialising in adult or something, then you might end up just not [1.5: Mhm] having the range of experiences where you'd actually come across someone maybe? [1.5: Mhm] And I suppose that's something lacking then in training...

2.4: It would [stutters] almost be a good way to test your skills, and to increase your knowledge...

Newly qualified staff implied that since qualifying they had encountered a steep learning curve through their experience in working with this client group:

3.2: ...I felt like I was colluding with him from the start, because I just had so little understanding of personality disorder in general, [3.1: Mhm] and there was so little teaching on it [3.1: Yeah] and there's so little experience that I just went [laughs] [3.1: laughs] straight in there and did exactly what I did with everyone else [laughs]

3.1: Yeah, me too, my biggest regret [3.2/3.3: laugh] I regret most since I qualified the things I've done in a sort of similar situation where I kind of, I went in doing exactly what I do with everyone else I meet and for (that very person) it was really problematic [3.2: Yeah] [3.3: Mm] and led to lots of stress and anguish

3.2: Mm

3.3: Sounds like it was probably quite an important learning experience, [3.1/3.2: laugh] [laughs] when you totally cock it up [laughs]

3.1/3.2: [laugh]

CPs at later stages in their careers appeared to look back on earlier experiences with clients with BPD with the benefit of hindsight, through having now had more experience with the client group:

4.2: ...first thing she said to me, as a kind of newly qualified person was, eh, something along the lines of 'Well I think all the problems started when I was thirteen and I was charged with attempted murder of my best friend', [4.1/4.3/4.4: laugh] [laughs] and I was like, oh my goodness, oh my goodness...panic, absolutely pure panic, trying to get through the rest of it and to be looking cool and calm and collected [laughs] and clearly not managing that at all, and I don't, you know, I guess being kind of new off the course, I don't think I'd really seen

anyone when I was a trainee with that kind of level of problem and kind of looking back, just from people I've seen, kind of makes me think...well she probably had a borderline personality disorder...and I just felt completely unprepared for that...and it was difficult for me to, to work with her because, I think, of my anxiety about her, at that time

The evidence for this sub-theme was also strengthened through the group dynamics in FGs 2 and 3, such as the knowing laughter about learning from mistakes in the above example from FG 3.

3.3.8.3 Value of Support

Most participants emphasised the importance of support from colleagues when working in the area of BPD. For many, this was in terms of good supervision:

1.2: ...I'd want my supervisor to have seen a few people as well [1.1/1.3/1.5: nod] because it's not gonna be much help if you're saying yeah there are all these behaviours and this is how I feel about it, if they've never had any experience of it [1.5: Mhm, mhm] that's not going to be very reassuring to me, so I'd really want to be able to speak to somebody who actually [pause] knew what, knew what it was like...

Many participants also highlighted the value of working within supportive team settings:

4.1: ...in the team, the people that got involved mostly, were the people that would be interested in supporting people with those types of difficulties...one of the people, psychologists in my team, that's her specialist area, she's done research on, so I guess that was good from that point of view...so you knew there was research going on, and people's interests and em, but then also knowing there were lots of [indistinct] other people...cos you need the support...I mean one of the things that [indistinct] was self-harm...and you know, people phoning and threatening something and you'd have to deal with that, and that would usually be at 5 'clock on a Friday and, you know, it was all those sorts of things, but if you work in a team people stay on later, and that's all very supportive, that there's maybe someone else to sort of be there and.....

Several participants even conveyed a sense of comfort in sharing the confusion over the topic within the FG setting:

1.5: ...I was just gonna say how helpful it was kinda talkin' about it [1.1/1.2/1.3/1.4: nod] to kinda think about the kinda issues [1.1: Mmm] that come up so that [stutters] if you do come across somebody, em, you're kinda know what –

1.2: Yeah

1.1: Mmm

1.4: And know that other people are thinkin' or feelin' the same way [1.5: Yeah] [1.1/1.2/1.3: nod]...so that you don't feel it's only you [whispers] that's crap! [laughs]

1.1: Yeah the kind of just, just the discussion about it and that everyone's kind of, goes a bit like 'Oh what am I doing here', [1.4: Mm] it's quite useful...

3.2: It's been really good talking about it actually, I've found, just, I think hearing other people's experiences, [3.1: Yeah] cos again, cos of the lack of training maybe, in it

Group agreement within FGs 1, 2, and 4 added further strength to the evidence for this sub-theme, such as the above group agreement in FG 1.

3.3.8.4 Potential of Psychology

Several participants, across all groups, suggested that clinical psychology has the potential to make a positive impact in the area of BPD:

4.3: ...psychologists can begin to do something with these guys...

For some, clinical psychology was seen as having the potential to make an impact by not restricting its role to purely individual client work:

2.1: There's possibly a quite good opportunity there to liase with psychiatry more, and do joint working and things like that more...and that would help in turn with things like consultancy and training with people who are involved more on a day to day basis with people with personality disorders, [2.2: Mhm] so I suppose it's kind of, there's an opportunity and an opening there I think [2.3: Mhm] [2.4: Mmm]...

2.1: ...working systemically with the friends and family of people, you know, people who are

married to somebody with borderline and things like that, I think that's probably another role where psychology could come in

3.3.8.5 Reflections on 'Improving Our Role'

CPs' views on improving the role of clinical psychology in this area have not been previously reported. However, the methodologies of both Brody & Farber (1996) and Servais & Saunders (2007) did not investigate this aspect in the questionnaires used. Yet, Walter *et al.* (2003), who did enquire about such issues in their questionnaire study, found that in line with the present study, hospital and community based mental health service staff reported to being willing to receive further training in 'managing' clients with BPD. On the other hand, Nehls' (2000) qualitative study did not report that the CMs interviewed conveyed a sense of improving the role of their profession. Perhaps this was not as relevant an issue for the participants in that study. Although the present study appears to be one of the first to report on participants' views on improving their role, this finding is consistent with the recommendations of authors of previous research in the area. For example, Markham & Trower (2003) recommend that nursing staff should receive supervision and training to address their attributions of control in clients with BPD, in order to promote sympathy and offset negative experiences. This fits well with CPs in the current study not only expressing the need for supervision and training for their own profession, but also a willingness to offer such support to other professions working in the area.

The emergence of the superordinate theme 'improving our role' is important, as it reveals that despite expressing negative perceptions and undesirable feelings in relation to clients with BPD, CPs in the present study are keen to have more experience with these clients, to learn more about them, and to work systemically to alter the 'unhelpful' system that unwittingly hurts them. This theme appears to offer some ways of dealing with the problems outlined in the superordinate theme 'working in contrast to the system'. Indeed, the apparent desire for learning, experience, and support in the area of BPD, may serve to counter the participants' own negative perceptions and undesirable feelings related to this client group.

It appears that improving the role of clinical psychology was important to the participants in the present study, regardless of the stages in their careers. However, the sub-theme ‘desire to learn more’ was particularly evident in the transcripts of trainees, suggesting that it is at the early stages in their careers that CPs may appreciate gaining knowledge in this area. It is also interesting to note that a trainee, 2.1, made a particularly significant contribution to the sub-theme of ‘potential of psychology’, in terms of working with carers and other professions. Perhaps this was as a result of this participant having a considerable amount of experience in learning disabilities services.

3.4 Key Relationships Between Themes

The superordinate themes are diagrammatically juxtaposed in Figure 3 (see section 3.3), to highlight the opposing relationships between them. In this way, ‘negative’ and ‘positive perceptions of the client’ can be viewed as opposite perceptions. Similarly, ‘undesirable’ and ‘desirable feelings in the psychologist’ can be viewed as opposite emotions. On the other hand, it is possible to view the ‘awareness of negativity’ and ‘trying to make sense of the chaos’ as opposite aspects of self-awareness. Finally, ‘working in contrast to system’ and ‘improving our role’ can be conceptualised as opposite systems. Such polarisation in the themes is yet another reflection of the ‘oscillating between extremes’ that has been conveyed. Further links between the themes, of a more causal nature, cannot be inferred from the current data. However, possible causal links between the themes, which could be investigated by future research, are suggested in section 4.5.2.

4. FURTHER REFLECTIONS

4.1 Summary of Findings

Analysing the FG interviews of 16 CPs (including both trainees and fully qualified staff) has revealed eight superordinate themes, which appear to capture the essence of their experiences and perceptions of clients with BPD.

Participants conveyed a range of **'negative perceptions of the client'**. Clients with BPD were perceived as different, or in some cases, odd, compared to other clients. They were viewed as controlling, manipulative, 'over the top', and as people who oscillate between extremes. Moreover, participants perceived these clients as limited in their ability to change.

A range of **'undesirable feelings in the psychologist'**, in relation to these clients, was also emphasised. While participants felt overwhelmed, and immersed in confusion and complexity in their work with clients with BPD, they also experienced a 'pressure to do something' to help them. In addition, they experienced feelings of frustration and anxiety. Such anxiety was often related to a perceived sense of danger regarding clients with BPD. Feelings related to low self-efficacy were also expressed, such as feelings of helplessness. Interestingly echoing their perceptions of clients with BPD, the psychologists also appeared to oscillate between extremes.

'Negative perceptions of the client', and 'undesirable feelings in the psychologist', were expressed by all participants, regardless of their career stages. However, there were some differences in the emergence of certain sub-themes within these superordinate themes. For example, it was only the fully qualified psychologists that reported oscillating between extremes.

Despite the presence of such negative themes, most participants also conveyed a sense of **'positive perceptions of the client'**, in that change was seen as a possibility, and some participants viewed these clients as being likeable. Similarly,

‘desirable feelings in the psychologist’ were also present, in that many participants conveyed a sense of empathy and interest in the client group, as well as some describing a feeling of reward from working with them. Although these two superordinate themes were manifested in the narratives of staff at different stages in their careers, they were more evident in the narratives of fully qualified staff.

A range of processes that CPs appear to engage in, when they are **‘trying to make sense of the chaos’** of the presenting problems of people with BPD, were identified. These included: searching for explanations; providing structure or boundaries in therapy; normalising the difficulties in BPD; working engagement; and working on different therapeutic levels. This overall superordinate theme was manifested in the narratives of all participants, regardless of the stage in their careers. However, there were some differences in the emergence of sub-themes within this superordinate theme. For example, the sub-theme of ‘working on engagement’ was mainly found in the narratives of fully qualified staff.

Despite engaging in such processes, it emerged that the CPs felt like they were often **‘working in contrast to system’** of the NHS and the medical model. Problems with the BPD diagnosis were emphasised, and the impact of psychology was perceived as limited, due to financial and time restraints, as well as other professionals being seen as unhelpful at times. This superordinate theme emerged in the transcripts of all participants, regardless of the stage in their careers.

An **‘awareness of negativity’** surrounding clients with BPD was conveyed. Within this superordinate theme there was an awareness of negative perceptions of such clients, both in terms of within other professions and psychology, including participants’ own personal perceptions. An awareness of avoidance behaviour used by CPs in relation to these clients being unhelpful, was also conveyed. Interestingly, some participants attempted to explore the reasons why negative perceptions of clients with BPD exist in staff.

A sense of a need to be **‘improving our role’** in the area of BPD, as well as ways of doing so, was expressed in terms of a desire to learn more about BPD, the value of experience in the area, and the value of support from colleagues when working with these clients. The potential of psychology was also emphasised, with particular reference to not restricting the role of psychology to purely individual client work. While this superordinate theme was present in the narratives of all participants, the sub-theme of ‘desire to learn more’ was particularly evident in those of trainees.

4.2 Implications

4.2.1 Concerns Regarding Negativity

As already discussed (see sections 3.3.1.6 and 3.3.2.8) ‘negative perceptions of the client’ and ‘undesirable feelings in the psychologist’ are superordinate themes that have also been validated by previous literature, with both other professions (e.g. Markham & Trower, 2003), as well as CPs (Brody & Farber, 1996; Servais & Saunders, 2007). Therefore, it could be argued that the present findings suggest that CPs are not any less prone to holding negative perspectives on this client group. Indeed, the present study suggests that the profession has still not moved on from such negative stereotyping.

The implications of such feelings and perceptions on CPs’ care-giving with clients with BPD are significant. As outlined in section 1.4.1, there are many ways in which negative perspectives may affect the therapeutic relationship. This is concerning given that research findings (Bateman & Fonagy, 2000) as well as clients with BPD themselves (Fallon, 2003) have indicated that the therapeutic relationship is an important factor in intervention for BPD.

Indeed, it is not only the therapeutic relationship that can be affected. The feeling of a ‘pressure to do something’ is akin to the enormous responsibility in staff referred to by Markham & Trower (2003), which can lead to staff ‘burnout’ (Brickman *et al.*, 1982). Negative perceptions can also inhibit the effectiveness of treatment (see

Servais & Saunders, 2007). Clinicians holding such views may avoid working with these clients in the first place, and people may also avoid seeking services needed due to a fear of encountering negative attitudes from staff (Wahl, 1999).

Given the recent recommendations from the BPS, that CPs should have a role in leadership in the area of BPD, the present findings raise further cause for concern. For example, if CPs are likely to be in the position of training other health professionals in the area of BPD, and as Servais & Saunders (2007) highlight, training may inadvertently amplify negative perceptions, the finding that CPs do hold such negative views of these clients implies that potentially, CPs training other health professionals may unintentionally perpetuate the negativity surrounding this client group. Furthermore, the public stigma of BPD may also be maintained by CPs with negative perceptions failing to challenge misconceptions of PD, and modelling inappropriate behaviour (Servais & Saunders, 2007). If such negative perceptions of staff become recognised out-with mental health services, implications for people with BPD may become even more widespread, for example, potentially affecting decisions in housing, employment, and social service settings (Markham, 2003).

4.2.2 Hope for Change

Encouragingly, the above negativity was certainly not the entirety of what was expressed by this sample of CPs. Significantly, the participants were aware of their own negativity surrounding clients with BPD, conveyed a sense of engaging in various processes in 'trying to make sense of the chaos' of these clients' difficulties, and despite reporting a sense of 'working in contrast to the system', expressed a need to improve their role in the area, including ways of doing so. Moreover, although not as richly represented across the narratives as 'negative perceptions of the client' and 'undesirable feelings in the psychologist', 'positive perceptions of the client' and 'desirable feelings in the psychologist' were conveyed. Crucially, these six themes have had either little or no mention in previous qualitative and quantitative research with other professions (e.g. Nehls, 2000; Markham, 2003) as well as in quantitative research with CPs in the US (Brody & Farber, 1996; Servais & Saunders, 2007).

This implies that the chosen methodology was effective in enabling these previously under-reported aspects of staff perspectives on clients with BPD to be revealed.

However, it is also possible that such differences in the findings are due to differences in the perspectives of other professions, and/or differences between staff in the UK and the US. Yet, it is not possible to assert what the reasons for the differences in the findings may be, as both the present study and that of Nehls (2000) are qualitative studies with relatively small sample sizes, and there are various methodological differences between Brody & Farber's (1996) and Servais & Saunders' (2007) studies and that of the present.

Nevertheless, despite the presence of 'negative perceptions of the client' and 'undesirable feelings in the psychologist', the present findings do imply that CPs are in a potentially suitable position to adopt the recommended role of clinical leaders in the area of BPD. This was suggested by the various processes the CPs in the present study appeared to engage in, in order to attempt to understand BPD and improve the service that clinical psychology provides in the area. Within the themes of 'trying to make sense of the chaos' and 'improving our role' several such processes were conveyed, for example, the use of formulation, viewing BPD on a continuum, and the consideration of working with different approaches with clients with BPD, which are all in line with the recent BPS recommendations for the role of the profession in this area (Alwin *et al.*, 2006).

Furthermore, the theme of 'working in contrast to system' was also consistent with the BPS stance, in that for example, the limited usefulness of PD diagnoses is acknowledged (Alwin *et al.*, 2006). While some aspects of this theme are concerning, for example, the finding that CPs feel the impact of their role is limited, perhaps if they adopt a role in leadership in the area, CPs may be in a position to prevent this. Indeed, the focus on improving their role pointed to several ways in which the challenges of 'working in contrast to the system' could be overcome. For example, the potential of psychology to work more closely with other professions in the area of BPD, may help to overcome some of the difficulties in sharing

information, which, as suggested under the sub-theme ‘exploring why’ (see section 3.3.7.3), may lead to negative perceptions of these clients.

4.2.3 Experiences and Perceptions at Different Career Stages

The findings imply that there may be some differences in the experiences and perceptions of clients with BPD between CPs at different stages in their careers. Firstly, trainee CPs appeared to have a lack of experience in working with clients with BPD, and claimed there was a lack of teaching in the area. However, all fully qualified staff in the study had experience of working with these clients, suggesting that CPs have a lack of training in a client group they are likely to be working with from the early stages of their careers. Indeed, a ‘desire to learn more’ was particularly evident in the transcripts of trainees, suggesting that it is at the early stages in their careers that CPs may appreciate gaining knowledge in this area. Furthermore, experience in working with the client group was seen as valuable by participants, and differences in the presence of certain themes in those who had experience in the area of BPD, may provide some support for this notion.

Namely, although negative perceptions and undesirable feelings in relation to clients with BPD were expressed regardless of the stage in their careers, in contrast to the findings of Markham (2003) and Brody & Farber (1996), who reported no improvements in perceptions or feelings in relation to these clients in staff at later stages in their careers, ‘positive perceptions of the client’ and ‘desirable feelings in the psychologist’ were more fully represented in the narratives of fully qualified staff. Methodological differences from both of these studies, as well as participants being in a different profession in Markham’s (2003) study, may account for this difference in the findings.

While the fully qualified CPs may not have been able to hold onto this positivity at all times, the findings suggest that they were beginning to develop an alternative positive perspective on these clients. Thus, longer experience in working with clients with BPD may lead to an improvement in perceptions and feelings of this client group.

Additionally, the sub-theme of 'working on engagement' was mainly identified in the narratives of fully qualified staff, and instead of focussing on only working around BPD, or on the symptoms 'on the surface', which was mainly evident in trainees' narratives, fully qualified staff highlighted difficulties with such approaches to BPD, and possible benefits to working at a 'deeper' level.

It is possible that the differences in the emergence of themes between trainees and fully qualified CPs were due to differences in levels of experience with clients with BPD. However, it may also have been due to other factors that may be different at later stages in careers, such as more knowledge, more opportunities to engage in longer-term therapies, or, as emphasised by Brody & Farber (1996), more awareness of their own feelings. Yet, positive perceptions and desirable feelings appeared to be most richly represented in the narratives of those fully qualified staff who had the most experience in working with clients with BPD, and participants appeared to draw on such experiences of working with clients with BPD to illustrate these themes, suggesting that experience with the client group may have influenced these perceptions and feelings. Undoubtedly one must be cautious when comparing and discussing any differences in themes between participants, as it is not possible to infer that such differences are due to factors such as level of experience in the area, or even stage in career, given the qualitative design and relatively small sample size.

4.3 Researcher Personal Reflections

In IPA the importance of the experiences and perceptions of the researcher, as well as the ways in which the research may have affected the researcher, are acknowledged (Willig, 2001). Being transparent about what some of these issues may be is in line with the assumption of IPA, that it is possible to have multiple interpretations of the same data. In other words, another researcher, with for example, a different research background, may have facilitated a different FG discussion, or an alternative interpretation of the data (Jordan *et al.*, 2007). It is for

these reasons that I have chosen to share the following excerpts from my reflexive diary with the reader.

4.3.1 Why am I Doing This?

Throughout the study, I reflected on what had led me to this area of research. In my initial diary entries I appear to emphasise a mismatch between my own experiences with these clients, and those that I had heard others portraying:

12/01/2007

I can't believe other peoples' reactions when I say that my thesis is in the area of BPD. It's the same when I tell people about working on the trial and how it involved visiting people with BPD in their homes. It's usually one of 'you're brave!' Even trying to get a clinical supervisor was difficult to begin with, with most psychologists I approached not feeling experienced enough in the area. You really do get a sense of people shying away from these clients...What you hear is a lot of negative attitudes about them but my experience of meeting them was far from it. They roused empathy and interest in me. Some of them were the most interesting, and often nicest, people I've ever met. But you just don't hear any of that. Maybe I want to find out if anyone else out there feels the same way.

The above excerpt was written before I conducted the FGs. Even during the groups I was sometimes very aware of the difference in my own perspective on these clients. It was often challenging to take the 'backseat' required. Thus, being permitted to ask 'does anyone see it differently?' was often a welcome relief when the discussion was centring around negative themes.

As my reflecting progressed, I began to wonder if there were any other reasons why I was researching this topic, other than the benefits to clinical practice. I wondered if I had any personal reasons for choosing the topic:

09/02/2007

...So maybe I want to find out why I think differently? Maybe this is actually about me wanting to learn more about myself? Did I miss something about these clients that everyone else can see?

16/04/2007

Thinking again why I might be doing this project (during the never-ending transcribing of the third focus group). Perhaps it's because I want to work in the area, so I want to know what staff feel like working in the area. I'm certainly getting a real insight into that now!

The frequent reflecting over the possible reasons why I was conducting the research was not only important for the purposes of transparency, but also in appearing to motivate me through the more challenging stages of the project. These stages are discussed under the following theme.

4.3.2 The Race Against Time

Much of the remainder of my diary revolved around the theme of a 'race against time'. Throughout this often stressful period, somewhat paradoxically, I found myself relating to several of the themes that had emerged in the analysis of the FG data. For example, I appear to have felt different emotions at the same time. I was, in a sense, 'oscillating between extremes'. In the following excerpt the emotions conveyed oscillate between anxiety surrounding the time-scale of the project, and excitement about the emerging data:

09/02/2007

...trying to get a time that suits all the experienced staff has been a nightmare. I've been panicking about that and about conducting the group. What if it goes wrong? What if it doesn't fit with IPA, or doesn't record?! Thankfully I did the pilot a few days ago and I think it went really well. The trainees actually felt they benefited from discussing the issues...

Been transcribing the first group today and actually enjoying it! Can see lots of themes coming up already. If all else fails, at least I have that data. All in all feeling a lot better about my study. Will feel even better once I have the last focus group arranged.

Feeling 'overwhelmed', and 'trying to make sense of the chaos', in terms of the depth of the data I was faced with, and the uncertainty of whether I was approaching

it correctly, were other themes that appeared to emerge from my diary. Indeed, I was consciously aware of this parallel:

29/04/2007

This is like a race against time. Not even had a chance to write down my reflections for ages. Transcribing took forever. Started the analysis last week and feeling like I'm lost in the data. When the themes have been coming clearer it's starting to make sense. The theme of 'trying to make sense of the chaos' really seems to sum up a lot about the project.

13/06/2007

Feeling a lot clearer about my themes now. I really think that talking them out to people has helped...I think getting lost is just part of the process you have to go through. I'm trying not to get too hung up on whether I've interpreted it 'right' anymore...This doesn't mean it's easy - quite the opposite! It just means you have to acknowledge yours is just one way of interpreting it, as a result of everything you're bringing to it. It's quite hard to step outside yourself and work out what this stuff is that you bring, especially when there's so little time...

Perhaps the parallels between the themes that emerged in my own diary and those in the FG analysis were projected onto me, as a result of being so immersed in the participants' narratives. On the other hand, perhaps such themes in my own reflections were projecting onto my analysis of the participants' narratives. It is impossible to now separate myself from the analysis. This realisation feels somewhat ironic, given that only recently, in the above excerpt, I was still struggling to see how I could be influencing, or be influenced by, the data.

4.4 Methodological Critique

4.4.1 Limitations

Undoubtedly, FGs highlight interesting issues regarding group dynamics (e.g. possible assumed consensus) and traditionally they have been used to identify themes or narratives present in the group as a whole (Smith, 2004). However, it could be argued that by using a participant based group analysis the full exploration of such group dynamics was sacrificed to the focus on individual narratives. Nevertheless,

the individual orientation to the analysis allowed the personal experience of the individuals to be explored in line with the IPA perspective, while utilising group factors in the data to enrich the evidence for the emergent themes. In this way, the researcher took advantage of valuable data on group dynamics that would not have been accessible in an individual interview.

Yet, a participant based analysis of FG data also raises the question of how representative of the individual the narratives actually were. As highlighted by Morgan (1988), there has been ample research conducted on the differences between group behaviour and that of the individual. More specifically, Krueger (1994) warns that FGs with existing work colleagues can result in extremely complex communication, and that it is impossible for the researcher to determine all the factors that influence group comments. For example, participants may be selective in what they say due to the presence of others in the group (Krueger, 1994). In the present study, for instance, it could be argued that participants may have felt inhibited in expressing certain views in the presence of those in more senior positions.

While it was felt that the culture of the department involved is one where open communication is encouraged, to further limit the inhibition of all views being expressed, FGs were designed to include those at similar stages in their careers (as far as this was practically possible), it was emphasised that there were no right or wrong answers, and the researcher encouraged all participants to express their own views. As discussed more fully in section 2.1, it has even been argued that FGs place a greater emphasis than individual interviews on the participants' points of view (Morgan, 1988), and can actually relax peoples' inhibitions (Krueger, 1994). Indeed, it appeared that this was possibly the case in the present study. For example, it was common for participants to remark that they were 'just thinking that' to one another. As described in section 3.2, despite slight variations in the levels of contributions, each participant appeared to 'tell their story'. Smith (2004) comments that the possibility of individuals being able to construct their own narratives despite the presence of the group is dependent on the interplay of several factors, including

participant characteristics and the topic of discussion. Perhaps participants being CPs, and therefore likely to be accustomed to group discussions, and the topic of clients with BPD not being a highly personal topic, may have aided this process.

It could also be argued that the internal validity of the present study has not been fully addressed, as it did not use the technique of respondent validation (the cross checking of provisional findings with participants). However, the appropriateness of respondent validation for all studies has been questioned, in that the researcher's aim of providing an overview may be different to the participants' individual concerns, leading to discrepancies in their accounts (Barbour, 2001). Furthermore, reconvening focus groups can be impractical and time-consuming for the participants (Barbour, 2005). In any case, while respondent validation can provide corroboration or support for findings, the absence of such validation does not refute existing findings (Barbour, 2001). As such, the cross checking of the coding by the supervisors (the outcome of which was agreement on all themes) was considered as sufficient validation of the themes in the current study.

Finally, the present findings are limited to the fairly homogenous participants in the study. The sample did not include CPs from different settings (e.g. forensic or learning disabilities services) or perhaps most notably, CPs who are 'experts' in the field of BPD, who may have conveyed different themes to those in the present study. Furthermore, the sample did not include any male participants. However, the majority of staff in the service studied are female, and the absence of males in the study is likely to be a reflection of this. Moreover, due to the qualitative methodology adopted, the present study did not aim to be representative, as data from a sample size large enough to be representative would be impossible to analyse with the depth required for this approach (Yardley, 2000). Yet it is important to be cautious when considering the recommendations for clinical practice (see section 4.5.1), which are based on the findings derived from the sample of CPs interviewed in the present study. Such recommendations may not be relevant to other CPs, particularly those who may have had more extensive experience in working with this client group, or who specialise in specific interventions for BPD, and as a result of

such expertise, may have conveyed different themes to those which emerged in the present study.

4.4.2 Strengths

The present study has drawn attention to topics that may be considered by some to be taboo: ‘borderline personality disorder’; and the examination of our own profession’s experiences and perceptions. It is critical that such areas of research are not avoided, as such avoidance may prevent potentially unhelpful perspectives from being identified. As a corollary, possible ways of improving services, to ensure that this client group receives the same quality of care afforded to others, may also be left unexplored. Thus, the present study is aptly timed, given the recent BPS recommendations that CPs should be clinical leaders in the area (Alwin *et al.*, 2006).

Furthermore, the naturally occurring FGs that were conducted discussed real-life experiences with clients with BPD, thus increasing the ecological validity of the study, and allowing the possibility of action research to take place. In this way, the discussions themselves gave rise to several suggestions for improvements to the role of clinical psychology in the area of BPD (see section 4.5.1). In addition, to our knowledge, the present study is the first to specifically investigate CPs perspectives on clients with BPD in the UK, and the first to have explored this qualitatively in any setting. Therefore, the present findings add to the validity of the quantitative studies on this topic conducted in the US (Brody & Farber, 1996; Servais & Saunders, 2007) and provide more ecologically valid findings for the UK.

Given the role of perceptions in care-giving (see sections 1.4.1 and 4.2.1), it is likely to be beneficial to the profession to be aware of the reported experiences and perceptions of the CPs. Although not generalisable, other CPs may find that they relate to the rich findings reported, and that perhaps their own perspectives are normalised as a result. This may be particularly helpful for some of the undesirable feelings reported, for example. It is also hoped that other CPs may relate to, or be inspired by, some of the suggestions for improving the role of the profession, which were highlighted by the participants.

Finally, the study demonstrates the application of IPA to FG data, adding to the small but growing amount of studies that have amalgamated these approaches (e.g. Jordan *et al.*, 2007). As such, the study supports Smith's (2004) claim that there is 'plenty of scope to push the boundaries' (p.51) of data collection methods in IPA. Thus, the present study has added to the growth of possibilities in qualitative research.

4.5 Recommendations

4.5.1 Clinical Practice

The FGs not only conveyed a sense of a need to improve the role of clinical psychology, but also generated ideas of how to do this, namely, providing more experience and teaching on BPD for trainees, as well more support and appropriate supervision for fully qualified CPs working with these clients. Ideas regarding systemic working, with carers and other professionals, such as joint working, were also suggested within the groups. It is recommended that such ideas are taken forward.

There are various ways in which the above ideas could be put into action. As the participants emphasised the value of team settings, in terms of, for instance, increased support from other staff, as well as increased awareness of research in the area of BPD, perhaps raising the awareness of the Scottish Personality Disorders Network may provide CPs who do not work in such team settings with a source to obtain such support and up to date knowledge from. Perhaps local groups for CPs or other professionals working with clients with BPD, or holding a shared interest in the client group, could be developed to provide a further, more immediate source of support. Indeed, if such groups were open to different professionals, it may also help to foster working relationships that would be helpful in any systemic work.

Given that participants reported finding the FGs particularly useful, perhaps further FGs within the service studied may serve to provide a regular forum for raising

continuing issues of concern in working with this client group, and generating further ideas for improving the role of clinical psychology in the area. Participants expressed a desire to learn more, and certainly improving knowledge of current theories on BPD is likely to help reduce stigma and improve care (Nehls, 1998). For example, Krawitz (2004) demonstrated that brief training in current concepts of diagnosis, aetiology, intervention and prognosis led to positive attitude change in mental health clinicians working with this client group. Thus, it is recommended that more opportunities for continuous professional development in the area of BPD, are provided and promoted to CPs. This will be critical if the profession is to adopt a role in clinical leadership in the area.

Furthermore, given that 'low self-efficacy' was conveyed in relation to working with clients with BPD, and the 'value of supervision' was also highlighted, it is recommended that models of supervision which encourage positive perceived self-efficacy, such as solution-focused supervision, are considered for use with CPs working in the area of BPD. The solution-focused model, which focuses therapists' strengths rather than weaknesses, has been demonstrated as contributing to positive perceived self-efficacy in trainee therapists (Koob, 1999). On the other hand, given the richness of the 'undesirable feelings in the psychologist' conveyed, which may be regarded to be countertransferential reactions, psychodynamic approaches to supervision, which emphasise the confrontation, understanding, and management of such feelings in order to facilitate therapeutic progress (Brody & Farber, 1996) may be particularly helpful for CPs working with these clients. In any case, as emphasised by the BPS, supervision for those working with clients with BPD should be regular, and should enable potential problems in therapy to be discussed at an early enough stage to preclude the development of more serious difficulties (Alwin *et al.*, 2006).

In light of the 'desire to learn more' expressed particularly by trainees, it is urged that the BPS recommendations (Alwin *et al.*, 2006), that more theoretical and practical teaching on assessment and intervention for PD, is provided on the Doctorate in Clinical Psychology training course, and opportunities for practical

experience with this client group are encouraged and provided in adult mental health placements, are taken forward.

4.5.2 Future Research

While suggestions regarding possible links between the themes emergent in the present study have been highlighted, such as ‘undesirable feelings in the psychologist’ possibly being projected onto the client with BPD, leading to ‘negative perceptions of the client’ (see section 3.3.2.8), it is not possible to make any causal inferences regarding such links. As such, it is recommended that future quantitative research investigates the origins of negative perceptions of clients with BPD, and what factors lead to positive perceptions and desirable feelings in relation to these clients. For instance, they may be attributable to other themes identified in the present study, such as, ‘trying to make sense of the chaos’, and/or some other factor, such as experience or knowledge.

Similarly, future quantitative research could investigate the noted differences in themes between CPs at different stages in their careers further. This would be important, as the absence of any improvements in perceptions, for example, may indicate that perhaps CPs are not maintaining their awareness of current theories on BPD, or that perhaps their experience is not serving to challenge their negative perceptions.

Finally, it is possible that CPs working in settings other than adult mental health services, such as learning disabilities services or forensic services, may have conveyed different themes to those in the present study. Future research may wish to replicate the present study with a homogenous group of CPs working in such services.

4.6 Conclusions

The present study has generated knowledge about CPs' experiences and perceptions of clients with BPD, which may affect how they work with this client group. Such knowledge is appropriately timed given the lack of research on the perspectives of this particular profession on the BPD client group, and the recent recommendations by the BPS that CPs should become clinical leaders in the area.

Negative perceptions and undesirable feelings were conveyed, raising concerns regarding the therapeutic relationship and the possibility of the unintentional perpetuation of the negativity surrounding this client group. Despite this, and the conveyed sense of 'working in contrast to the system', CPs were aware of the negativity from their own profession and others. They engaged in a range of processes in 'trying to make sense of the chaos' of these clients' difficulties, and appeared to emphasise a need to improve their role in the area, as well as suggestions of how to do so. Moreover, positive perceptions and desirable feelings were also conveyed in relation to clients with BPD. Therefore, the present findings contrast with the pejorative connotations of the BPD label being seen as unchangeable, and serve to challenge the notion that these clients are only associated with negative feelings in staff.

To conclude, despite concerns regarding the negativity conveyed, the current findings have been illuminating in that the positive themes conveyed and new ideas generated engender a sense of hope for change. The discovery of such themes has been truly inspiring to the researcher, and it is hoped, to others 'trying to make sense of the chaos'.

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APPENDICES

Appendix I:	DSM-IV Criteria for Borderline Personality Disorder
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APPENDIX I:

DSM-IV Criteria for Borderline Personality Disorder

DSM-IV Criteria for Borderline Personality Disorder

- frantic efforts to avoid real or imagined abandonment
- a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
- identity disturbance (markedly and persistently unstable self-image or sense of self)
- impulsivity, in at least two areas that are potentially self-damaging (for example, spending, sex, reckless driving)
- recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- affective instability due to a marked reactivity of mood (for example, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- chronic feelings of emptiness
- inappropriate, intense, anger or difficulty controlling anger (for example, frequent displays of temper)
- transient, stress-related paranoid ideation or severe dissociative symptoms

(APA, 1994)

APPENDIX II:

Inclusion / Exclusion Criteria

Inclusion / Exclusion Criteria

Inclusion Criteria:

- trainee clinical psychologists
- fully qualified clinical psychologists working with adults with mental health problems
- fully qualified clinical psychologists working with adults with severe and enduring mental health problems
- fully qualified clinical psychologists working in primary care
- fully qualified clinical psychologists working in community mental health teams

Exclusion Criteria:

- fully qualified clinical psychologists working in child and adolescent, or learning disabilities services

APPENDIX III:

Invitational Letter to Participants

Date

Clinical Psychologist's name
Clinical Psychologist's address

Dear (Clinical Psychologist's name)

Clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder': A qualitative study

I am writing to invite you to take part in the above study, which I am conducting in part fulfilment of the degree of doctorate in Clinical Psychology at the

The purpose of the study is to explore clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder' (BPD), and any differences in such perceptions between staff with different lengths of experience in working as clinical psychologists. However, **it does not matter if you have little or even no experience in working with this client group.**

Participation would involve attending one focus group session, held within

The focus group participants will be asked (as a group) a series of open-ended questions on this topic. The session is expected to last no longer than 90 minutes. **Full confidentiality and anonymity will be ensured.**

This research is relevant at a time when the British Psychological Society recommends that clinical psychologists' skills are required in clinical leadership, in order to reflect the government's policy on services for personality disorder. Extending our understanding of clinical psychologists' perceptions of clients with BPD is an area of importance because such perceptions may have an impact on the way in which we work with these clients. It is hoped that the sharing of perceptions about clients with BPD will help clinical psychologists identify their own assumptions and difficulties of working with this group.

I will telephone you within the next few days to see if you would be interested in participating. An information sheet providing full details on the study will be

provided to those who are interested. However, you may take up to a fortnight to decide whether or not you wish to participate.

In the meantime, if you have any questions or concerns, please telephone me on
Alternatively, you can email me at

Yours sincerely

APPENDIX IV:

Participant Information Sheet

Participant Information (19 December 2006)

Clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder': A qualitative study

You have been asked to participate in a research project, which is being conducted for educational purposes (in part fulfillment of the researcher's degree of doctorate in Clinical Psychology at the _____). Before you decide please take time to read the following information carefully. Discuss it with others if you wish.

It should also be noted that the study is being reviewed by _____ Research Ethics Committee.

What is the purpose of the study?

The study aims to explore clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder' (BPD) and any differences in such perceptions between staff with different lengths of experience in working as clinical psychologists. However, it does not matter if you have little, if any, experience of working with this client group.

Extending our understanding of healthcare workers' perceptions of clients with BPD is an area of importance because such perceptions may have an impact on the way in which people work with these clients. Previous literature reports the perceptions of other healthcare workers of clients with BPD. However, no studies have as yet investigated the perceptions of clinical psychologists. This is particularly relevant at a time when the British Psychological Society recommends that clinical psychologists' skills are required in clinical leadership, in order to reflect the government's policy on services for personality disorder.

What will my role be if I decide to take part?

Your role will be to participate in one focus group (which is one of several being conducted), during which you will be asked a series of open-ended questions on this subject. You will have the right to withdraw consent at any time. The group will be conducted sensitively and with regard for the safety and respect for the opinions of those involved. Agreement to protect the confidentiality of other group members will be made explicit at the outset, with everyone being asked to honour each others confidentiality.

Instead of answering the questions back to the researcher, please try to discuss them together as a group, as naturally as you can. Please discuss the issues honestly. The focus group is expected to run for no longer than an hour and a half and will be audio recorded throughout. The focus groups will be held in the Clinical Psychology Service meeting room in between January and March 2007.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential.

The discussion will be audio recorded, in order for the researcher to transcribe it. You will be asked to state your name at the beginning of the recording (to link voices to names for the transcription process), but only the researcher will listen to the recording of the discussion. The researcher will listen through the recordings whilst reading the transcripts to check the accuracy of the transcripts and make corrections as necessary. Each participant will be allocated a participant identification number. The transcripts will not contain your name, but instead they will contain your identification number. Each of the focus groups will also be given an identification number, and this will be the label on each of corresponding recordings. Due to the method of analysis, several researchers may be required to read the transcripts, but participants will be kept anonymous, as the transcripts will only contain identification numbers.

The recordings and transcripts will be kept in a locked filing cabinet. The recordings will be magnetically erased following the completion and approval of the doctoral thesis, and the transcripts will be shredded five years following this. Verbatim quotation may be used in the thesis (which may be published) but the participants as well as the health board will remain anonymous throughout the thesis (and publication). Finally, you are requested to maintain confidentiality of the views of other participants.

What will happen to the findings of the study?

The results of the research will be disseminated through the doctoral thesis, and it is intended that this will be submitted for publication in an academic journal. As stated above, you will not be identified in the thesis or publication. The results will also be presented to local psychology staff (without identifying the participants) and may be presented at conferences (without identifying the participants or health board).

What if I have a complaint to make?

If you feel concerned about any aspect of the conduct of the research, you can report a complaint to:

(Academic Supervisor)

Contact address:

Contact tel.

APPENDIX V:

Participant Consent Form

Focus Group Identification Number:
Participant Identification Number:

CONSENT FORM

Title of Project: Clinical psychologists' experiences and perceptions of clients with
'borderline personality disorder': A qualitative study

Please tick box

1. I confirm that I have read and understand the information sheet dated 19 December 2006 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐
3. I understand that the focus group session will be audio recorded

☐
4. I agree to respect other participants' confidentiality

☐
5. I agree to take part in the above study

☐

Name of participant

Date

Signature

Name of researcher

Date

Signature

APPENDIX VI:

Interview Guide

Interview Guide

‘Could we start by each person taking a turn to state their name (just so I can link your voices to your names when I am transcribing) and some basic background information (i.e. what your post is, years since qualifying/stage in training)?’

- **Think back and tell us what experience you have had with clients with borderline personality disorder?**
(if none – prompt with ‘What do you think about that?’)
- **Think back and tell us about a situation that you have experienced as a clinical psychologist with a client with borderline personality disorder – one that really stands out in your mind?**
(if none – prompt with ‘What sorts of situations do you expect clinical psychologists would experience?’)
- **Tell us what clients with borderline personality disorder are like?**
(if cannot – prompt with ‘Close your eyes and think of the words ‘borderline personality disorder’what comes to mind?’)
- **Think back and tell us how working with clients with borderline personality disorder makes you feel?**
(if cannot – prompt with ‘How does the thought of working with these clients make you feel?’)
- **Tell us about your role in the area of borderline personality disorder?**
(if cannot – prompt with ‘Tell us about the role of clinical psychology is in this area?’)
- **Tell us about the main issues involved with dealing with clients with borderline personality disorder?**
(if cannot – prompt with ‘What are the main things you would have to deal with when working with these clients?’ or ‘What do you expect would be the main things?’)
- **Tell us what you think the most important issue in this discussion has been?**
- **Has anything been missed from the discussion?**

Throughout: **Use probes:**
Can you tell me more about that?

Would you give an example of that?
Is there anything else?
How did that make you feel?
What do you think about that?

Encourage different opinions:
What has been your experience?
Does anyone see it differently?

APPENDIX VII:

Example of Table of Themes (Participant 3.2)

Key: Emerged in participant's narrative

Did not emerge in participant's narrative

Themes: Participant 3.2

Themes	Example from transcript	Page/line number
1. Negative perceptions of the client <ul style="list-style-type: none"> - different, odd - controlling, manipulative - over the top - ability to change limited - self-absorbed - oscillating between extremes 	'with other people' 'playing into something' 'every little thing' 'I might <u>not</u> get to the point that she'll feel much better' 'love hate relationship'	5/46 12/45 45/8 42/23-25 28/48
2. Positive perceptions of the client <ul style="list-style-type: none"> - possibility of change - likeable 	'he has made loads of changes'	25/45-46
3. Undesirable feelings in the psychologist <ul style="list-style-type: none"> - overwhelmed - confusion, complexity - pressure to do something - frustration - anxiety - low self-efficacy - oscillating between extremes 	'bombarded' 'I don't know how far to prod, and how, you know, how far to go into it' 'so much pressure was on me to make this person better' 'it was kind of like 'Aarrh she drives me mad!'' 'a bit worried' 'haven't been able to save them' 'extremes of emotions you feel'	4/16 53/8-10 10/25-26 28/50 15/7 51/30
4. Desirable feelings in the psychologist <ul style="list-style-type: none"> - empathy - interest - reward 	'might not feel ready for it' 'amazed'	53/13-14 14/50
5. 'Trying to make sense of the chaos' <ul style="list-style-type: none"> - searching for explanations 	'I think she directs it at herself because she feels she can't actually let it out at the person'	14/46-48

<ul style="list-style-type: none"> - providing structure, boundaries - normalisation - working on engagement - working on different levels 	<p>‘the boundaries are more clear’</p> <p>‘maybe I’ve got personality disorder’</p> <p>‘you have to be so cautious what [3.1: Yeah] you say’</p> <p>‘if you don’t go there then you, we’re gonna stay stuck’</p>	<p>35/11</p> <p>31/28</p> <p>45/6-7</p> <p>41/49-50</p>
<p>6. Working in contrast to the system</p> <ul style="list-style-type: none"> - problems with diagnosis - impact of psychology limited 	<p>‘an easy way out’</p> <p>‘that’s really problematic’</p>	<p>32/24</p> <p>27/34</p>
<p>7. Awareness of negativity</p> <ul style="list-style-type: none"> - awareness of negative perceptions - awareness of avoidance being unhelpful - exploring why 	<p>‘oh gosh that’s horrible to say isn’t it’</p> <p>‘so easy to go into superficial stuff’</p> <p>‘and you can <u>see</u> that’</p>	<p>34/45</p> <p>11/40-41</p> <p>25/43-44</p>
<p>8. Improving our role</p> <ul style="list-style-type: none"> - desire to learn more - value of experience - value of support - potential of psychology 	<p>‘I still feel like I’ve so much to learn’</p> <p>‘one case that’s, I feel is teaching me a bit more about it’</p> <p>‘hearing other people’s experiences’</p> <p>‘I wonder whether that is maybe the role of psychology’</p>	<p>5/43-44</p> <p>52/38-39</p> <p>55/1</p> <p>34/41-42</p>

APPENDIX VIII:

Example of Table of Group Factors (Focus Group 3)

Key: **Emerged in group narrative**

Did not emerge in group narrative

Group Factors - Focus Group 3

Themes	Example from transcript	Page/line number
1. Negative perceptions of the client <ul style="list-style-type: none"> - different, odd - controlling, manipulative - over the top - ability to change limited - self-absorbed - oscillating between extremes 	Laughter / Agreement	16/31
2. Positive perceptions of the client <ul style="list-style-type: none"> - possibility of change - likeable 	Agreement	36/12-13
3. Undesirable feelings in the psychologist <ul style="list-style-type: none"> - overwhelmed - confusion, complexity - pressure to do something - frustration - anxiety - low self-efficacy - oscillating between extremes 	Agreement Agreement Agreement Agreement	25/1 15/11-12 42/7 8/46
4. Desirable feelings in the psychologist <ul style="list-style-type: none"> - empathy - interest - reward 	Agreement Agreement	25/26-27 48/32
5. 'Trying to make sense of the chaos' <ul style="list-style-type: none"> - searching for explanations - providing structure, boundaries - normalisation - working on engagement - working on different levels 	Agreement Agreement Agreement Agreement	35/6 31/32 46/10 41/40-41

<p>6. <i>Working in contrast to the system</i></p> <ul style="list-style-type: none"> - problems with diagnosis - impact of psychology limited 		
<p>7. <i>Awareness of negativity</i></p> <ul style="list-style-type: none"> - awareness of negative perceptions - awareness of avoidance being unhelpful - exploring why 		
<p>8. <i>Improving our role</i></p> <ul style="list-style-type: none"> - desire to learn more - value of experience - value of support - potential of psychology 	Agreement	9/6

APPENDIX IX:

Excerpt from Coded Transcript (Focus Group 3)

1 looking back
 2 -sees too much
 3 learned not to do
 4 this now
 5
 6 had to raise self
 7 -bring control to
 8 things?
 9
 10 spoke of feelings in
 11 supervision - used feelings
 12 to understand what
 13 going on
 14 turning point
 15 -sense of hope
 16 let client feel
 17 normal
 18 feeling lost still,
 19 helplessness
 20 confused. usually
 21 trails off -
 22 confused, don't
 23 know how feel?
 24 don't know how to
 25 express how feel?
 26
 27 feeling lost - interesting
 28 overwhelming
 29
 30 don't know what to do
 31 stutters - conveys
 32 confusion. questions
 33 -sense of confusion
 34 'resort' to prescription
 35 - indicates knows
 36 it's unhelpful
 37 works on that but
 38 as easier
 39 but still get lost
 40 easy to avoid
 41 underlying issues
 42 'I just feel - just'
 43 indicates knows
 44 unhelpful
 45 overwhelmed
 46 laughs knows
 47
 48 acknowledging
 49 role of past
 50

of, made the relationship a bit too matey
 and [3.1: Mm] but I had to almost kind
 of reassert myself as the therapist and,
 and this is kind of what's happening and
 I know the last time I talked to you guys
 in supervision was about, you know, this
 sense of getting stuck with her [3.1:
 nods] and um, and actually saying to her
 [3.1: Mhm] that I, that I felt stuck, um,
 and that was probably a real [stutters]
 turning point in many ways because she
 said 'Oh it makes me feel like I'm, I'm
 maybe not as abnormal because you can
 feel stuck too', that was quite..... but
 what I just, I just don't know where I'm
 going with her and also because she's an
 inpatient I feel, 'Oh well, the sixteen
 sessions won't count, [3.1: laughs] I can
 see her for a year or two years it's okay,
 [3.3: Mm] it just almost takes the
 pressure off of me I guess maybe [3.3:
 Mm] but I really, I feel really kind
 of.....

3.3: It's interesting [stutters] that sense
 of feeling lost, with these kind of
 patients, cos I know that with my, with
 my person I just feel like this, 'Oh this is
 overwhelming, [stutters] what can I do,
 where do I start?' [3.2: Mm] [stutters]
 and I often feel, feel lost, and I then I
 kind of resort to trying to do like, you
 know, the real kind of [stutters]
 hierarchical prescriptive stuff [3.2:
 Mhm] and, you know, starting at like the
 easiest [3.1: Yeah] most straightforward
 point but, you know, you just get lost
 very easily

3.2: It's so easy to go into the
 superficial stuff isn't it? [3.3: Mmm]
 [3.1: nods] I just feel -

3.3: When you're feeling overwhelmed
 [laughs] by someone

3.2: Yeah, absolutely [nods], I just
 know with her that I know now a lot
 more, a heck of a lot of really horrible
 stuff happened in her past, and well I

value of experi
 providing
 structured, bound
 value of suppo
 searching for
 explanations
 possibility of
 change
 normalisation
 low self-effic
 premis to do
 something
 confusion
 complexity
 intent
 overwhelmed
 confusion
 complexity
 awareness of
 avoidance
 unhelpful
 nothing on differ
 levels
 confusion, complex
 awareness of
 being unhelpful
 overwhelmed
 nothing on
 different
 levels

think lots of abuse and, and bullying and criticism and stuff, and kind of, as soon as you get there, she starts saying 'I don't know', and all of those things, but rather than maybe gently taking that through I'm 'Oh don't worry [3.1: Mm] that's okay we don't have to go there [3.3: Mm] lets go to somewhere superficial [3.1: Mhm / laughs] like I don't know, playing tennis!' [3.1/3.3: laugh] (but then they look at me), [3.1: laughs] which is bizarre cos usually I'm, you know, with other people I'm usually quite, quite good at maybe gently taking it a bit further and actually talking about how, it must be really hard [3.1: Mhm] to talk about these things but with her, I don't know whether that is because she's got personality disorder, and actually been diagnosed with it, or whether it's because she's an inpatient, this pressure [3.3: Mhm] um, I'm so conscious of not wanting to put her under pressure, [3.1: Mhm] um I don't know, I can't really figure it out yet

3.3: And is there a sense that she's quite fragile?

3.2: There is but then she gives, gives you signs that she's so clearly not fragile [3.3: Mm] at all, in fact we've talked about it, I wouldn't say we've talked about it really in depth but I did say, I find myself having a really quiet voice with her [whispers] like talking like this 'Oh are you okay?' [raises voice again] and I never do that, [3.1: Mhm] and I actually said to her '[stutters] I get really frustrated with myself that I do that with you, because, you know, because actually the way that you respond to me, [stutters] you do know what you're talking about and I just wonder whether I'm playing into something' and actually she responded, I mean she kinda said, she said she didn't really know how I usually am, which is true, she wouldn't, um I guess she didn't really go much

anxious
avoidance
being unhel

11

different

confusion, con-
fusions in
diagnosis
premises too
something

searching for
explanation

don't to clear
more

confusion;
complexity

different, odd

frustration
searching for
explanation
controlling, many

1 bizarre - sense of
2 being perplexed by
3 own reactions
4 struggling, emphasises
5 confusion
6 set different channels
7 other clients

9 sense of oddness

15 'usually' separates
16 from other clients

18 feels different
19 avoids exploring

21 'she makes me'
22 attributes different
23 to client

32 seeing for
33 specific symptoms
34 around BPD -
35 not BPD

38 strange compared
39 to others - eg OCD

41 'ever' emphasised
42 to convey no chance
43 of having (OCD) chance
44 - implies is a chance
45 if BPD

47 sense of danger
48 worries of habituating
49 will harm someone

50 not on habituating with BPD
don't tell plan
stutters - confused
what to do

not to grips, feels quiet

further into it but yes, bizarre, [stutters] I don't, I don't actually -

3.1: It's that whole thing of you acting differently than you would normally?

3.2: Yeah, yeah. [nods]

3.1: It's funny that isn't it?

3.2: [nods]

3.3: Well yeah that's the same with my woman as well, really, cos I would usually jump straight in and, you know, [stutters] try to get to grips with all the messy exploratory stuff but with her I feel like, 'Let's just stick to this, [3.2: Yeah] [3.1: Mhm / laughs] let's leave all that', so [3.1: Uh huh] she makes me, well I feel like I need to act differently than I do with my other patients as well

3.1: Yeah

I: Could you tell us a bit more about that experience that you've had?

3.3: Um, what can I tell you, well [stutters] the reason that I'm seeing her really is um, she has social anxiety and intrusive thoughts, em and really the reason why I'm sort of, em, I've been asked to get involved is for the intrusive thoughts, so we're kind of working on that but then it's eh it's a bit strange because most people, like in an OCD sense, when they have intrusive thoughts, say about harming someone, it's like the last thing they would ever do, and so you can kind of work on habituating them, but she has, she thinks about em harming her mother, but then in the past she's actually tried to harm her mother so, [3.1: Hm] so that makes it all quite messy and em so yeah, I haven't actually really got to grips [stutters] with what I'm going to do em but that's where we decided just to start it off because, because things do seem

confusion, complexity
different, odd

different, odd

different, odd

group agreement
- different odd
different, odd

nothing on
different level

different, odd

ability to ~~control~~ anxiety

low self-efficacy
confusion, complexity

1 repeat what do
 2 many strong
 3 difficulty
 4
 5 sense of hope for
 6 change changing
 7 good patch
 8
 9 (at the moment)
 10 implies won't last
 11 just now! emphasises
 12 this at end
 13 'intensity'
 14
 15 'anger' 'harm'
 16 - sense of danger
 17
 18 uncertain if
 19 capable of harming
 20 people
 21 repeats interesting
 22
 23 shutting - searching
 24 for reason - thinks
 25 it's anger
 26
 27 changes sense from
 28 'did' to 'do', as
 29 realised previous
 30 about it now.
 31
 32 sense of being
 33 unpredictable
 34 sense of danger
 35 woman's anger
 36 will get out of
 37 control
 38 self-harms to
 39 control anger
 40
 41
 42
 43
 44
 45
 46
 47
 48
 49
 50

quite messy, all that said at the moment she's going through quite a good, a good patch because um she, her and her boyfriend, em, take drugs, and he's moved out now and em she's on a methadone programme and her life has become full of routine again and that seems to have had an effect on everything, including her intrusive thoughts, so she's going through quite a good patch just now [3.2: Mm] so um [stutters] she's interesting
 3.2: Actually you just talking about that kind of sense of anger, or I mean those intrusive thoughts of harming, [3.3: Yes] just made me think of my, my woman and her talking about not being able to express anger [3.3: Yes] because when she has angry feelings she actually wants to hurt people that she's angry with, um, and she feels that if she let out the anger she would hurt someone [3.1: Mhm] and I actually don't know whether she has hurt someone in the past
 3.3: Yes, it's interesting that because I do think this woman [stutters] it is her way of, um, becoming angry, [stutters] it's you know, [3.2: Mm] it's an intrusive thought, and yeah and [stutters] maybe that's, that's perhaps the root, the root to go down, [3.1: Mm] trying to help her express her anger in a safe way
 3.2: [stutters] It feels quite, I don't know how you feel about yours, but I know I feel very, I did actually, I do actually feel quite nervous about it [3.3: Mhm] because, because this is quite a big woman and um, and I could see how her anger getting out of control, cos it has got out of control on the ward, more in terms of how she directs it at herself, she self-harms a lot as well, [3.3: Mhm] um but I think she directs it at herself because she feels she can't actually let it out at the person she's angry with, [3.3: Mhm] um, and I know recently, actually in the last session, I, I was quite amazed

confusion, comp
 possibility
 change

ability to
 change
 limited
 interest

anxiety

11 11

interest

searching for
explanation!

anxiety

11 11

searching for
explanation

that we talked about all sorts of feeling states and, and that at the, just at the end of the session she, she gave two examples of being quite angry with a member of staff, [stutters] with two different members of staff, and that's why I got a bit worried that, you know, that maybe I would be splitting the team if I got too much into it, but at the same time I was maybe also a bit nervous about her getting very angry [3.1/3.3: Mhm / nod] and sitting there in this room, actually without a bleep, which they usually give to me, [3.1/3.3: Mhm] um you know, what do I do if she does get very angry?

3.3: Mmm, yes, I suppose with my em woman, because I know that in the past when she has been unwell she, she has actually tried to harm people [3.2: Oh right] and she's, you know, tried to em, you know, she's had to like hoard her medications so she can, you know, [stutters] do stuff with it and, and I think when you know that someone has, has really does have the potential [stutters] it does, I think that must be affect how much you feel [3.2: Mmm] like you want to explore that sort of, that powerful emotion

3.1: [nods]

3.2: Mm, I suppose it's the, I don't know if it's just with this patient group, but there's a lot of uncertainty, which, which I think usually, I feel we can deal with a bit more, like I feel with other patients the uncertainty is maybe more around what you might not know about their past, and that's okay, but with them it's more about how they will react, I find [3.3: Mm] [3.1: Yeah] that you find yourself really wondering if I say that, yeah are they just going to blow up [3.3: Mhm] or, you know.....

3.1: It's funny cos I was just thinking back to this man that I was seeing, who

interest

anxiety

group agreement - anxiety

low self-eff

anxiety

nothing on different level

confusion completely different

anxiety group agreement - anxiety

APPENDIX X:

Letter of Approval – Local Research Ethics Committee

15 January 2007

Dear

Full title of study: Clinical psychologists' experiences and perceptions of clients with 'borderline personality disorder': A qualitative study.
REC reference number: 06/S0501/98

Thank you for your letter of 19 December 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered and approved by the Chair on 12 January 2007.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the research site(s) taking part in this study. The favourable opinion does not therefore apply to any site at present. I will write to you again as soon as one Local Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at sites requiring SSA.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		13 November 2006
Investigator CV	1.0	13 November 2006
Protocol	4.0	13 November 2006
Covering Letter		13 November 2006
Compensation Arrangements		28 July 2006
Interview Schedules/Topic Guides	3.0	13 November 2006
Letter of invitation to participant	1.0	30 October 2006
Participant Information Sheet: Participant Information Sheet	3	19 December 2006
Participant Consent Form: Consent Form	3	19 December 2006
Response to Request for Further Information		19 December 2006
Letter form Sponsor and Funder		07 November 2006
Changes to Application		

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

With the Committee's best wishes for the success of this project

Yours sincerely



Chair

REC

Email:

Enclosures:

*Standard approval conditions, SL-AC2
Site approval form*

Copy to:

R&D Officer,

APPENDIX XI:

Letter of Approval – Research and Development Management

Date: 19 January 2007

Your Ref:

Our Ref:

Direct Line:

Email:

Dear

Following the approval of the Research Ethics Committee on 12 January 2007, I am pleased to confirm that I formally gave Divisional Management approval to "Clinical Psychologist's experiences and perceptions of clients with 'borderline personality disorder': A qualitative study" on 19 January 2007.

The Research Governance Framework for Health and Community Care applies to all research undertaken within The Framework sets out standards and details the key responsibilities of key individuals, including the research sponsor, principle investigator, other researchers and supervisors of students undertaking research.

All those involved in the project will be required to work within accepted guidelines of research governance and IHC-GCP guidelines.

A copy of the Framework and links to background annex material can be accessed via the Chief Scientist Office website at <http://www.show.scot.nhs.uk/cso/ResGov/ResGov.htm> and ICH-GEP guidelines may be found at <http://www.ich.org/pdf/ICH/eb.pdf>

You (or the local principal investigator) will be required to provide a progress report on your study at the end of the study. We will also require a copy of the final report, when available. You will also be asked annually to complete a form on the activity taking place in relation to the study within for each financial year during which it is active here. The appropriate forms will be provided to you by the Research and Development office when they are needed.

Yours sincerely

Medical Director

APPENDIX XII:

Transcription Key

Transcription key

Underlining of word(s)(_____): word(s) emphasised by the participants

Six ellipsis (.....): speaker trailed off

Hyphen (-) at the end of a word: cut off abruptly

Square brackets ([]): enclose the researcher's comments, including sounds that were difficult to describe, for example, [stutters], features of the interaction, such as [nods], and short interrupting responses from other participants, for example, [1.1: Mhm]

[Removed]: denotes text that has been removed to protect the anonymity of the participants

[Indistinct]: denotes an inability to distinguish what was said

Round brackets: enclose the researcher's reasonable guess as to what was said when she was uncertain

Three ellipsis (...): denote missing text (where the researcher deemed such text to be less relevant)

As illustrations of the group dialogue between participants will often be presented, a line will separate quotes presented together when they were not part of a dialogue between those participants, to allow the reader to see that these are isolated quotations removed from their context